

103<sup>D</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 5228

To reform the health insurance market, to promote the availability and continuity of health coverage, to remove financial barriers to access, to reform the medicaid program, to enhance health care quality, to contain costs through market incentives and administrative reforms, to provide incentives to purchase long-term care insurance, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 6, 1994

Mr. ROWLAND (for himself, Mr. COOPER, Mr. BILIRAKIS, Mr. GRANDY, Mr. MCCURDY, Mr. GOSS, Mr. PARKER, Mr. HASTERT, Mr. STENHOLM, and Mr. THOMAS of California) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, the Judiciary, and Veterans' Affairs

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## A BILL

To reform the health insurance market, to promote the availability and continuity of health coverage, to remove financial barriers to access, to reform the medicaid program, to enhance health care quality, to contain costs through market incentives and administrative reforms, to provide incentives to purchase long-term care insurance, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUB-**  
 2 **TITLES.**

3 (a) SHORT TITLE.—This Act may be cited as the  
 4 “Bipartisan Health Care Reform Act of 1994”.

5 (b) TABLE OF TITLES AND SUBTITLES IN ACT.—The  
 6 following are the titles and subtitles contained in this Act:

**TITLE I—ASSURING AVAILABILITY AND CONTINUITY OF  
HEALTH COVERAGE**

Subtitle A—Insurance Reforms

Subtitle B—Benefits

Subtitle C—Employer Responsibilities

Subtitle D—Standards and Certification; Enforcement; Preemption

Subtitle E—Multiple Employer Health Benefits Protections and Related Provisions

Subtitle F—Definitions; General Provisions

**TITLE II—REMOVAL OF FINANCIAL BARRIERS TO ACCESS**

Subtitle A—Tax Deductibility for Individuals and Self-Employed

Subtitle B—Premium and Cost-Sharing Subsidy Program for Low-Income Individuals

**TITLE III—MEDICAID REFORMS**

Subtitle A—Treatment of Acute Care Benefits for AFDC and Non-cash Beneficiaries

Subtitle B—Flexibility in Expenditures for Supplemental Benefits for AFDC and Non-cash Beneficiaries

Subtitle C—Increased State Flexibility in Contracting for Coordinated Care

Subtitle D—Additional Medicaid Reforms

**TITLE IV—ACCESS IMPROVEMENTS**

Subtitle A—Expanding Access in Underserved Areas

Subtitle B—Improved Access in Rural Areas

Subtitle C—Academic Health Centers

Subtitle D—United States-Mexico Border Health Commission

**TITLE V—HEALTH CARE QUALITY ENHANCEMENT**

Subtitle A—Quality Assurance

Subtitle B—Primary Care Provider Education

**TITLE VI—MARKET INCENTIVES TO CONTAINING COSTS**

Subtitle A—Facilitating Establishment of Health Plan Purchasing Organization (HPPOs)

Subtitle B—Preemption of State Benefit Mandates and Anti-Managed Care Laws

Subtitle C—Malpractice Reform

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Subtitle D—Administrative Simplification  
Subtitle E—Fair Health Information Practices  
Subtitle F—Antitrust  
Subtitle G—Fraud and Abuse  
Subtitle H—Billing for Laboratory Services

**TITLE VII—MEDICARE**

Subtitle A—Increased Beneficiary Choice; Improved Program Efficiency  
Subtitle B—Savings

**TITLE VIII—INCENTIVES TO PURCHASE LONG-TERM CARE  
INSURANCE**

Subtitle A—Establishment of Federal Standards for Long-term Care Insurance  
Subtitle B—Tax Treatment of Long-term Care Insurance

**TITLE IX—DEPARTMENT OF VETERANS AFFAIRS**

**TITLE X—MISCELLANEOUS SAVINGS PROVISIONS**

Subtitle A—Automobile Insurance Coordination  
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1 **TITLE I—ASSURING**  
2 **AVAILABILITY AND CONTINUITY**  
3 **OF HEALTH COVERAGE**

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## Subtitle F—Definitions; General Provisions

## PART 1—DEFINITIONS

- Sec. 1901. General definitions.  
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## PART 2—REPORT AND RECOMMENDATIONS ON HEALTH COVERAGE AND ACCESS

- Sec. 1911. Objective of full access and coverage.  
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## 1 Subtitle A—Insurance Reform

2 **PART 1—GUARANTEED ACCESS TO HEALTH**

### 3 COVERAGE

**4 SEC. 1001. GUARANTEED OFFER BY CARRIERS.**

(a) IN GENERAL.—Each carrier that offers health insurance coverage in the individual/small group market in a fair rating area (as defined in section 1903) shall make available, to each qualifying individual (as defined in section 1904(3)) or small employer (covered in such market) in such fair rating area—

1 (1) qualified standard coverage consistent with  
2 section 1102, and

3 (2) subject to subsection (b), qualified high-de-  
4 ductible coverage consistent with section 1103.

5 (b) HIGH-DEDUCTIBLE COVERAGE.—

6 (1) EXCEPTION FOR HEALTH MAINTENANCE  
7 ORGANIZATIONS.—The requirement of subsection  
8 (a)(2) shall not apply with respect to health insur-  
9 ance coverage that—

10 (A) is provided by a Federally qualified  
11 health maintenance organization (as defined in  
12 section 1301(a) of the Public Health Service  
13 Act), or

14 (B) is not provided by such an organiza-  
15 tion but is provided by an organization recog-  
16 nized under State law as a health maintenance  
17 organization or managed care organization or a  
18 similar organization regulated under State law  
19 for solvency.

20 (2) LIMITATION ON OFFER OF HIGH-DEDUCT-  
21 IBLE COVERAGE.—Qualified high-deductible coverage  
22 may not be made available by a carrier to a qualify-  
23 ing individual (or to a small employer with respect  
24 to an employee) unless the carrier also makes avail-  
25 able qualified standard coverage that has identical

1       benefits (other than the amount of the deductible)  
2       and the individual or employee demonstrates to the  
3       carrier that the individual or employee has available  
4       assets (as defined by the Secretary) equal to at least  
5       the deductible amount established under section  
6       1104(b)(1) applicable to the high-deductible cov-  
7       erage. A carrier may not make available to an indi-  
8       vidual health coverage (other than coverage for sup-  
9       plemental benefits) the actuarial value of which is  
10      less than the actuarial value of qualified high-de-  
11      ductible coverage, unless the individual has available  
12      assets (as defined by the Secretary) equal to at least  
13      the deductible amount of the coverage offered.

14           (3) OPTION TO OFFER MEDISAVE COVERAGE.—  
15      The offer of high-deductible coverage under sub-  
16      section (a)(2) may be accompanied by the contribu-  
17      tion by an employer to a medical savings account (in  
18      accordance with section 7705 of the Internal Reve-  
19      nue Code of 1986).

20           (c) COVERAGE OF ENTIRE RATING AREA.—

21           (1) IN GENERAL.—With respect to each fair  
22      rating area for which a carrier offers health insur-  
23      ance coverage, the carrier shall provide for coverage  
24      of benefits for items and services furnished through-  
25      out the fair rating area.

1           (2) SPECIAL RULE FOR CARRIERS OFFERING  
2           COVERAGE IN MULTI-STATE METROPOLITAN STATIS-  
3           TICAL AREAS.—In the case of a carrier that offers  
4           qualified health insurance coverage in the individual/  
5           small employer market in a portion of a State that  
6           is located in an interstate metropolitan statistical  
7           area, the carrier may not provide such coverage with  
8           respect to an individual or employer in such metro-  
9           politan statistical area unless the carrier also offers  
10          such coverage in other portions of the area located  
11          in other States.

12          (3) SPECIAL RULE FOR COVERAGE THROUGH  
13          MANAGED CARE ARRANGEMENT.—In the case of cov-  
14          erage offered by a carrier or under a group health  
15          plan to the extent that it provides benefits through  
16          a managed care arrangement in a fair rating area,  
17          this subsection shall not be construed as requiring  
18          the establishment of facilities throughout the area, if  
19          the facilities are located consistent with section  
20          1002(b)(1).

21          (d) FAMILY COVERAGE OPTION.—The offer of cov-  
22          erage under this section with respect to an individual shall  
23          include the option of coverage of family members of the  
24          individual.



1 (e) LIMITATION ON CARRIERS.—A carrier may not  
2 require an employer under a group health plan to impose  
3 through a waiting period for health coverage under a plan  
4 or similarly require a limitation or condition on health cov-  
5 erage or benefits based on—

6 (1) the health status of an individual,

7 (2) claims experience of an individual,

8 (3) receipt of health care by an individual,

9 (4) medical history of an individual,

10 (5) receipt of public subsidies by an individual,

11 or

12 (6) lack of evidence of insurability of an individ-  
13 ual.

14 **SEC. 1002. GUARANTEED ISSUE BY CARRIERS.**

15 (a) IN GENERAL.—Subject to subsections (b) and (c)  
16 and section 1003, each carrier that offers health insurance  
17 coverage in the individual/small group market in a fair rat-  
18 ing area—

19 (1) must accept every small employer in the  
20 area that applies for such coverage during an enroll-  
21 ment period provided under section 1005; and

22 (2) must accept for enrollment under such cov-  
23 erage every qualifying individual (and family mem-  
24 ber of such an individual) who applies for enrollment  
25 during an enrollment period provided under section

1       1005 and may not place any restriction on the eligi-  
2       bility of an individual to enroll so long as such indi-  
3       vidual is a qualifying individual.

4       (b) SPECIAL RULES FOR MANAGED CARE ARRANGE-  
5       MENTS.—In the case of coverage offered by a carrier or  
6       under a group health plan that provides benefits through  
7       a managed care arrangement in a fair rating area, the  
8       carrier or plan—

9               (1) need not establish facilities for the delivery  
10       of health care services throughout the area so long  
11       as such facilities are located in a manner that does  
12       not discriminate on the basis of health status of in-  
13       dividuals residing in proximity to such facilities, and

14              (2) may deny such coverage in a fair rating  
15       area to employers or individuals if the organization  
16       demonstrates to the applicable regulatory authority  
17       that—

18                   (A) it will not have the capacity to deliver  
19       services adequately to enrollees of any addi-  
20       tional groups or additional enrollees because of  
21       its obligations to existing group contract hold-  
22       ers and enrollees, and

23                   (B) it is applying this paragraph uniformly  
24       to all employers and individuals without regard  
25       to the health status, claims experience, or dura-

1           tion of coverage of those employers and their  
2           employees.

3 Coverage may be denied under paragraph (2) only if the  
4 denial is applied during a consecutive period of at least  
5 180 days.

6       (c) SPECIAL RULE FOR FINANCIAL CAPACITY LIM-  
7 ITS.—In addition to the authority provided under sub-  
8 section (b)(2), in the case of coverage offered by any car-  
9 rier, the carrier may deny coverage to a small employer  
10 or individual if the carrier demonstrates to the applicable  
11 regulatory authority that—

12           (1) it does not have the financial reserves nec-  
13           essary to underwrite additional coverage, and

14           (2) it is applying this subsection uniformly to  
15           all employers and individuals without regard to the  
16           health status, claims experience, or duration of cov-  
17           erage of those employers and their employees.

18 Coverage may be denied under this subsection only if the  
19 denial is applied during a consecutive period of at least  
20 180 days.

21 **SEC. 1003. GUARANTEED RENEWAL.**

22       (a) LIMITATION ON TERMINATION BY CARRIERS.—  
23 A carrier may not deny, cancel, or refuse to renew health  
24 coverage of a qualifying individual or eligible employer

1 within a type of coverage option described in section  
2 1903(15) except—

3 (1) on the basis of nonpayment of premiums,

4 (2) on the basis of fraud or misrepresentation,

5 or

6 (3) subject to subsection (b), in a fair rating  
7 area because the carrier is ceasing to provide any  
8 health insurance coverage in the individual/small  
9 group market within such type of coverage option in  
10 the area.

11 (b) LIMITATIONS ON MARKET EXIT BY CARRIERS.—

12 (1) NOTICE, ETC.—Subsection (a)(3) shall not  
13 apply to a carrier ceasing to provide health insur-  
14 ance coverage unless—

15 (A) such termination of coverage takes ef-  
16 fect at the end of a contract year, and

17 (B) the carrier provides notice of such ter-  
18 mination to employers and individuals covered  
19 at least 30 days before the date of an annual  
20 open enrollment period established with respect  
21 to the employer or individual under section  
22 1005.

23 (2) LIMITATION ON REENTRY IN INDIVIDUAL/  
24 SMALL GROUP MARKET.—If a carrier ceases to offer  
25 or provide health insurance coverage in an area with

1       respect to the individual/small group market for a  
2       type of coverage option, the insurer may not offer  
3       health insurance coverage in the area in such market  
4       within such type of coverage option until 5 years  
5       after the date of the termination.

6       (c) RULE FOR MULTIEMPLOYER PLANS AND CER-  
7       TIFIED MULTIPLE EMPLOYER HEALTH.—A multiem-  
8       ployer plan and a certified multiple employer health plan  
9       may not cancel coverage or deny renewal of coverage  
10      under such a plan with respect to an employer other  
11      than—

12               (1) for nonpayment of contributions,

13               (2) for fraud or other misrepresentation by the  
14      employer, or

15               (3) because the plan is ceasing to provide any  
16      coverage in a geographic area.

17      **SEC. 1004. RESTRICTING PREEXISTING CONDITION EXCLU-**  
18                                      **SIONS.**

19      (a) IN GENERAL.—Except as provided in this section,  
20      a carrier or group health plan providing health coverage  
21      may not exclude health coverage with respect to services  
22      related to treatment of a condition based on the fact that  
23      the condition of an individual existed before the effective  
24      date of coverage of the individual.

25      (b) LIMITED 6-MONTH EXCLUSION PERMITTED.—

1           (1) IN GENERAL.—Subject to paragraph (2)  
2           and subsections (c) through (e), a carrier or group  
3           health plan providing health coverage may exclude  
4           health coverage with respect to services related to  
5           treatment of a condition of an individual based on  
6           the fact that the condition existed before the effec-  
7           tive date of coverage of the individual only if the pe-  
8           riod of the exclusion does not exceed 6 months be-  
9           ginning on the date of coverage.

10           (2) CREDITING OF PREVIOUS COVERAGE.—

11           (A) IN GENERAL.—A carrier or group  
12           health plan providing health coverage shall pro-  
13           vide that if a covered individual is in a period  
14           of continuous coverage (as defined in subpara-  
15           graph (C)) as of a date upon which coverage is  
16           initiated or reinitiated, any period of exclusion  
17           of coverage with respect to a preexisting condi-  
18           tion (as defined in subparagraph (B)) for such  
19           services or type of services shall be reduced by  
20           1 month for each month in the period of contin-  
21           uous coverage.

22           (B) PREEXISTING CONDITION DEFINED.—

23           In this paragraph, the term “preexisting condi-  
24           tion” means, with respect to health coverage, a  
25           condition which has been diagnosed or treated

1           during the 3-month period ending on the day  
2           before the first date of such coverage (without  
3           regard to any waiting period).

4           (C) PERIOD OF CONTINUOUS COVERAGE.—

5           In this part, the term “period of continuous  
6           coverage” means the period beginning on the  
7           date an individual has health coverage (or cov-  
8           erage under a public plan providing medical  
9           benefits) and ends on the date the individual  
10          does not have such coverage for a continuous  
11          period of more than 3 months (or 6 months in  
12          the case of an individual who loses coverage due  
13          to involuntary termination of employment, other  
14          than by reason of an employee’s gross mis-  
15          conduct).

16          (c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—

17          Any exclusion of coverage under subsection (b)(1) shall  
18          not apply if the exclusion relates to pregnancy.

19          (d) EXCLUSION NOT APPLICABLE TO NEWBORNS  
20          AND ADOPTED CHILDREN.—

21               (1) NEWBORNS.—Any exclusion of coverage  
22               under subsection (b)(1) shall not apply to a child  
23               who is covered at the time of birth and remains in  
24               a period of continuous coverage after such time.

1           (2) ADOPTED CHILDREN.—Any exclusion of  
2           coverage under subsection (b)(1) shall not apply (be-  
3           ginning on the date of adoption) to an adopted child  
4           who is covered at the time of adoption and remains  
5           in a period of continuous coverage after such time.

6           (e) EXCLUSION NOT APPLICABLE TO INDIVIDUALS  
7           ENROLLED OR ENROLLING DURING CERTAIN OPEN EN-  
8           ROLLMENT PERIODS.—

9           (1) INDIVIDUALS ENROLLING DURING PE-  
10          RIOD.—In the case of an individual who enrolls and  
11          obtains coverage during an open enrollment period  
12          described in section 1005(b), any exclusion of cov-  
13          erage under subsection (b)(1) shall not apply so long  
14          as the individual remains in a period of continuous  
15          coverage.

16          (2) INDIVIDUALS ENROLLED AT BEGINNING OF  
17          PERIOD.—In the case of an individual who has  
18          health coverage as of the first day of the initial open  
19          enrollment period described in section 1005(b)(1),  
20          any exclusion of coverage under subsection (b)(1)  
21          shall not apply as of such date and so long as the  
22          individual is in a period of continuous coverage.

23          (f) APPLICATION OF RULES BY CERTAIN HEALTH  
24          MAINTENANCE ORGANIZATIONS.—A health maintenance  
25          organization that provides health insurance coverage shall



1 not be considered as failing to meet the requirements of  
2 section 1301 of the Public Health Service Act notwith-  
3 standing that it provides for an exclusion of the coverage  
4 based on a preexisting condition consistent with the provi-  
5 sions of this part so long as such exclusion is applied con-  
6 sistent with the provisions of this part.

7 **SEC. 1005. ENROLLMENT PERIODS.**

8 (a) IN GENERAL.—Each carrier and each group  
9 health plan providing health coverage (and each health  
10 plan purchasing organization under subtitle A of title V)  
11 in the individual/small group market shall permit qualify-  
12 ing individuals and eligible employers to obtain health cov-  
13 erage from the carrier or group health plan during each  
14 enrollment period provided under this section.

15 (b) OPEN ENROLLMENT PERIODS FOR WHICH PRE-  
16 EXISTING CONDITION EXCLUSIONS WAIVED.—

17 (1) INITIAL PERIOD.—There shall be an initial  
18 open enrollment period, with respect to individuals  
19 and employees who are residents of a State, during  
20 the 60-day period beginning on January 1, 1997.

21 (2) INDIVIDUALS ELIGIBLE FOR SUBSIDIES.—  
22 There shall be an individual open enrollment period  
23 with respect to an individual at the time the individ-  
24 ual first becomes eligible for any premium assistance  
25 under part A of title XXI of the Social Security Act,

1 during the 60-day period beginning on the first date  
2 the individual meets eligibility criteria within any  
3 12-month period.

4 (3) COURT ORDERS.—If a court has ordered  
5 that coverage be provided for a spouse or child of an  
6 employee or individual under health coverage of the  
7 employee or individual, there shall be an open enroll-  
8 ment period during the 30-day period beginning on  
9 the date of issuance of the court order.

10 (4) ENROLLMENT OF NEWBORNS AND NEWLY  
11 ADOPTED CHILDREN.—There shall be an open en-  
12 rollment period with respect to a newborn child and  
13 a newly adopted child during the 30-day period be-  
14 ginning on the date of the birth or adoption of a  
15 child, if family coverage is available as of such date.

16 (c) ANNUAL OPEN ENROLLMENT PERIODS FOR  
17 WHICH PREEXISTING CONDITION EXCLUSIONS MAY  
18 APPLY.—

19 (1) IN GENERAL.—Each carrier and each group  
20 health plan providing health coverage (and each  
21 health plan purchasing organization under subtitle A  
22 of title V) in the individual/small group market shall  
23 provide for at least one annual open enrollment pe-  
24 riod (of not less than 30 days) each year. Such pe-

1        riod shall be in addition to the open enrollment peri-  
2        ods described in subsection (b).

3            (2) COORDINATION.—

4                    (A) CARRIERS IN INDIVIDUAL/SMALL  
5        GROUP MARKET.—Such annual open enrollment  
6        periods with respect to carriers in the individ-  
7        ual/small group market are subject to coordina-  
8        tion by States.

9                    (B) GROUP HEALTH PLANS.—Such annual  
10       open enrollment periods with respect to any  
11       group health plan are subject to coordination in  
12       order to meet the requirement of section  
13       1201(a)(2)(F).

14       (d) OTHER OPEN ENROLLMENT PERIODS FOR  
15       WHICH PREEXISTING CONDITION EXCLUSIONS MAY  
16       APPLY.—

17            (1) TERMINATION OF RESIDENCE AREA.—For  
18       each qualifying individual, at the time the individual  
19       terminates residence in the service area of coverage  
20       provided by a carrier to the individual, there shall be  
21       an open enrollment period (of not less than 30 days)  
22       during which the individual may enroll in health cov-  
23       erage.

24            (2) FAMILY OR EMPLOYMENT CHANGES.—In  
25       the case of a qualifying individual who—

1 (A) through divorce or death of a family  
2 member experiences a change in family com-  
3 position, or

4 (B) experiences a change in employment  
5 status (including a significant change in the  
6 terms and conditions of employment or the  
7 terms and conditions of employment of a  
8 spouse),

9 there shall be an open enrollment period (of at least  
10 30 days) in which the individual is permitted to  
11 change the individual or family basis of coverage or  
12 the health coverage in which the individual is en-  
13 rolled. The circumstances under which such enroll-  
14 ment periods are required and the duration of such  
15 periods shall be specified by the Secretary.

16 (3) ENROLLMENT DUE TO LOSS OF PREVIOUS  
17 COVERAGE.—In the case of a qualifying individual  
18 who—

19 (A) had health coverage at the time of an  
20 individual's enrollment period,

21 (B) stated at the time of such period that  
22 having other health coverage was the reason for  
23 declining enrollment, and

24 (C) lost the other health coverage as a re-  
25 sult of the termination of the coverage, termi-

1           nation or reduction of employment, or other  
2           reason, except termination at the option of the  
3           individual,

4           there shall be an open enrollment period during the  
5           30-day period beginning on the date of termination  
6           of the other coverage.

7           (4) ENROLLMENT AT TIME OF MARRIAGE.—

8           There shall be an open enrollment period with re-  
9           spect to the spouse of an individual (including chil-  
10          dren of the spouse) during the 30-day period begin-  
11          ning on the date of the marriage, if family coverage  
12          is available as of such date.

13          (5) NO EFFECT ON COBRA CONTINUATION BEN-  
14          EFITS.—Nothing in this subsection shall be con-  
15          strued as affecting rights of individuals to continu-  
16          ation coverage under section 4980B of the Internal  
17          Revenue Code of 1986, part 6 of subtitle B of title  
18          I of the Employee Retirement Income Security Act  
19          of 1974, or title XXII of the Public Health Service  
20          Act.

21          (e) PERIOD OF COVERAGE.—

22          (1) IN GENERAL.—In the case of a qualifying  
23          individual who enrolls under health coverage during  
24          an open enrollment period under this section, cov-  
25          erage shall begin on such date (not later than the

1 first day of the first month that begins at least 15  
2 days after the date of enrollment) as the Secretary  
3 shall specify, consistent with this subsection.

4 (2) COVERAGE OF FAMILY MEMBERS.—In the  
5 case of an open enrollment period described in sub-  
6 section (b)(3), (b)(4), or (d)(4), the Secretary shall  
7 provide for coverage of family members to begin as  
8 soon as possible on or after the date of the event  
9 that gives rise to the special enrollment period (or,  
10 in the case of birth or adoption, as of the date of  
11 birth or adoption).

12 **SEC. 1006. TREATMENT OF RELIGIOUS FRATERNAL BENE-**  
13 **FIT SOCIETIES.**

14 (a) IN GENERAL.—Sections 1001 and 1002 shall not  
15 apply to any religious fraternal benefit society in existence  
16 as of September 1993, which—

17 (1) bears the risk of providing insurance to its  
18 members, and

19 (2) is an organization described in section  
20 501(c)(8) of the Internal Revenue Code of 1986  
21 which is exempt from taxation under section 501(a)  
22 of such Code.

23 (b) DEFINITION.—In subsection (a), the term “fra-  
24 ternal benefit society” includes any affiliate or wholly-  
25 owned subsidiary of a fraternal benefit society, including

1 a health maintenance organization insofar as it is utilized  
2 directly or indirectly to provide managed care to members  
3 of the society.

4 **PART 2—PROVISION OF BENEFITS**

5 **SEC. 1011. STANDARDS FOR MANAGED CARE ARRANGE-**  
6 **MENTS.**

7 (a) APPLICATION OF REQUIREMENTS.—Each group  
8 health plan, and each carrier providing health insurance  
9 coverage, that provides for health care through a managed  
10 care arrangement (as defined in section 1903(12)(A))  
11 shall comply with the applicable requirements of this sec-  
12 tion.

13 (b) SCOPE OF ARRANGEMENTS WITH PROVIDERS.—

14 (1) ACCESS TO CARE.—The entity providing for  
15 a managed care arrangement with respect to health  
16 coverage shall enter into such agreements with  
17 health care providers (including primary and spe-  
18 cialty providers, such as providers for children) or  
19 have such other arrangements as may be necessary  
20 to assure that covered individuals have reasonably  
21 prompt access through the entity's provider network  
22 to all items and services contained in the package of  
23 benefits for which coverage is provided (including ac-  
24 cess to emergency services on a 24-hour basis where  
25 medically necessary), in a manner that assures the

1 continuity of the provision of such items and serv-  
2 ices. Such access shall take into account the diverse  
3 needs of enrollees and proximity to the workplaces  
4 or residences of enrollees.

5 (2) ACCESS TO CENTERS OF EXCELLENCE.—

6 (A) IN GENERAL.—The entity providing  
7 for a managed care arrangement under health  
8 coverage shall demonstrate that covered individ-  
9 uals (including individuals with chronic dis-  
10 eases) have access through the entity's provider  
11 network to specialized treatment expertise.  
12 Such entity may demonstrate such access  
13 through contracts with centers of excellence de-  
14 scribed in subparagraph (B).

15 (B) DESIGNATION OF CENTERS OF EXCEL-  
16 LENCE.—The Secretary shall establish a proc-  
17 ess for the designation of facilities, including  
18 children's hospitals and other pediatric facili-  
19 ties, as centers of excellence for purposes of this  
20 paragraph. A facility may not be designated un-  
21 less the facility is determined—

22 (i) to provide specialty care,

23 (ii) to deliver care for complex cases  
24 requiring specialized treatment and for in-  
25 dividuals with chronic diseases, and



1 (iii) to meet other requirements that  
2 may be established by the Secretary relat-  
3 ing to specialized education and training of  
4 health professionals, participation in peer-  
5 reviewed research, or treatment of patients  
6 from outside the geographic area of the fa-  
7 cility.

8 (3) CHOICE OF PERSONAL PHYSICIAN.—The en-  
9 tity providing for a managed care arrangement  
10 under health coverage shall permit each enrollee to  
11 choose a personal physician from among available  
12 participating physicians and change that selection as  
13 appropriate.

14 (c) PROVISION OF EMERGENCY CARE SERVICES.—

15 (1) IN GENERAL.—The entity providing for a  
16 managed care arrangement under health coverage  
17 must cover medically necessary emergency care serv-  
18 ices provided to covered individuals (including trau-  
19 ma services, such as those provided by designated  
20 trauma centers), without regard to whether or not  
21 the provider furnishing such services has a contrac-  
22 tual (or other) arrangement with the entity to pro-  
23 vide items or services to covered individuals and, in  
24 the case of services furnished for the treatment of  
25 an emergency medical condition (as defined in sec-

1       tion 1867(e)(1) of the Social Security Act), without  
2       regard to prior authorization.

3           (2) DESIGNATED TRAUMA CENTERS DE-  
4       FINED.—In paragraph (1), the term “designated  
5       trauma center”—

6           (A) has the meaning given such term in  
7       section 1231 of the Public Health Service Act,  
8       and

9           (B) includes (for years prior to 2001) a  
10      trauma center that—

11           (i) is located in a State that has not  
12      designated trauma centers under section  
13      1213 of such Act, and

14           (ii) the Secretary finds it meets the  
15      standards under such section to be a des-  
16      ignated trauma center.

17      (d) DUE PROCESS STANDARDS RELATING TO PRO-  
18      VIDER NETWORKS.—

19           (1) STANDARDS FOR SELECTION OF PROVIDERS  
20      FOR NETWORK.—

21           (A) ESTABLISHMENT.—The entity provid-  
22      ing for a managed care arrangement under  
23      health coverage shall establish standards (in-  
24      cluding criteria for quality, efficiency,  
25      credentialing, and services) to be used by the

1 entity for contracting with health care providers  
2 with respect to the entity's provider network.  
3 Such standards shall be established in consulta-  
4 tion with providers who are members of the net-  
5 work, including providers who are members of  
6 the advisory committee established under para-  
7 graph (3)(D).

8 (B) DISTRIBUTION OF INFORMATION.—  
9 Descriptive information regarding these stand-  
10 ards and criteria shall be made available to en-  
11 rollees, providers who are members of the net-  
12 work, and prospective enrollees and prospective  
13 participating providers, including notice of when  
14 applications for participation will be accepted.

15 (C) NOTICE OF DENIALS.—The entity  
16 shall provide written notice to the provider of  
17 any denial of an application to participate in  
18 the provider network.

19 (2) TERMINATION PROCESS.—

20 (A) IN GENERAL.—The entity may not ter-  
21minate or refuse to renew a participation agree-  
22ment with a provider in the entity's provider  
23network unless the entity provides written noti-  
24fication to the provider of the entity's decision  
25to terminate or refuse to renew the agreement.

1           The notification shall include a statement of the  
2           reasons for the entity's decision, consistent with  
3           the standards established under paragraph (1).

4           (B) TIMING OF NOTIFICATION.—The en-  
5           tity shall provide the notification required under  
6           subparagraph (A) at least 45 days prior to the  
7           effective date of the termination or expiration of  
8           the agreement (whichever is applicable). The  
9           previous sentence shall not apply if failure to  
10          terminate the agreement prior to the deadline  
11          would adversely affect the health or safety of a  
12          covered individual.

13          (3) REVIEW PROCESS.—

14               (A) IN GENERAL.—The entity shall provide  
15               a process under which the provider may request  
16               a review of the entity's decision to terminate or  
17               refuse to renew the provider's participation  
18               agreement. Such review shall be conducted by a  
19               group of individuals the majority of whom are  
20               health care providers who are members of the  
21               entity's provider network or employees of the  
22               entity, and who are members of the same pro-  
23               fession as the provider who requests the review.

24               (B) COUNSEL.—If the provider requests in  
25               advance, the entity shall permit an attorney

1           representing the provider to be present at the  
2           provider's review.

3           (C) REVIEW ADVISORY.—The findings and  
4           conclusions of a review under this paragraph  
5           may be advisory and non-binding.

6           (D) ADVISORY COMMITTEE.—The entity  
7           shall establish an advisory committee of partici-  
8           pating physicians with whom it consults, on an  
9           advisory basis, on the termination of physicians  
10          who have been participating in the provider net-  
11          work. In making recommendations to the en-  
12          tity, such an advisory committee shall consider  
13          such features of the physician's practice, relat-  
14          ing to case mix and age of patients, as may  
15          lead the physician to have higher than expected  
16          treatment costs for the patients of the physician  
17          who are enrollees.

18          (4) CONSTRUCTION.—Nothing in this sub-  
19          section shall be construed to affect any other provi-  
20          sion of law that provides an appeals process or other  
21          form of relief to a provider of health care services  
22          or an entity providing for a managed care arrange-  
23          ment.

24          (e) NO REFERRAL REQUIRED FOR OBSTETRICS AND  
25          GYNECOLOGY.—A carrier or group health plan may not

1 require an individual to obtain a referral from a physician  
2 in order to obtain covered items and services from a physi-  
3 cian who specializes in obstetrics and gynecology.

4 **SEC. 1012. UTILIZATION REVIEW.**

5 (a) ESTABLISHMENT OF STANDARDS BY SEC-  
6 RETARY.—The Secretary shall establish standards for uti-  
7 lization review programs, consistent with subsection (c),  
8 and shall periodically review and update such standards  
9 to reflect changes in the delivery of health care services.  
10 The Secretary shall establish such standards in consulta-  
11 tion with appropriate parties.

12 (b) REQUIRING REVIEW TO MEET STANDARDS.—A  
13 group health plan or carrier providing health insurance  
14 coverage may not deny coverage of or payment for items  
15 and services on the basis of a utilization review program  
16 unless the program meets the standards established by the  
17 Secretary under this section.

18 (c) REQUIREMENTS FOR STANDARDS.—Under the  
19 standards established under subsection (a)—

20 (1) individuals performing utilization review  
21 may not receive financial compensation based upon  
22 the number of denials of coverage;

23 (2) negative determinations of the medical ne-  
24 cessity or appropriateness of services or the site at

1 which services are furnished may be made only by  
2 clinically qualified personnel;

3 (3) the utilization review program shall provide  
4 for a process under which an enrollee or provider  
5 may obtain timely review of a denial of coverage, in-  
6 cluding upon request a review conducted by the med-  
7 ical director of the carrier or plan or a physician  
8 designated by the carrier or plan;

9 (4) utilization review shall be conducted in ac-  
10 cordance with uniformly applied standards that are  
11 based on currently available medical evidence; and

12 (5) providers shall participate in the develop-  
13 ment of the utilization review program.

14 (d) PREEMPTION.—For provision preempting State  
15 laws relating to utilization review, see section 6103.

16 **SEC. 1013. REQUIREMENTS FOR ARRANGEMENTS WITH ES-**  
17 **SENTIAL COMMUNITY PROVIDERS.**

18 (a) REQUIREMENT.—

19 (1) IN GENERAL.—Subject to subsection (d),  
20 each group health plan and each carrier providing  
21 qualified health coverage to individuals residing in a  
22 fair rating area (or service area in the case of a car-  
23 rier that is a health maintenance organization) shall,  
24 with respect to at least one essential community pro-  
25 vider (as defined in subsection (c)) within each class

1 of such a provider (as described in paragraph (2))  
2 located within the area, enter into a written provider  
3 participation agreement (described in subsection (b))  
4 with the provider, unless all the providers in the  
5 class have declined to enter into such a contract with  
6 the plan or carrier.

7 (2) CLASS DEFINED.—For purposes of the  
8 paragraph (1), providers described in each para-  
9 graph of subsection (c) shall constitute a separate  
10 “class” of providers.

11 (b) PARTICIPATION AGREEMENT.—A participation  
12 agreement between a group health plan or carrier and an  
13 essential community provider under this subsection shall  
14 provide that the plan or carrier agrees to treat the pro-  
15 vider in accordance with terms and conditions at least as  
16 favorable as those that are applicable to other providers  
17 with a participation agreement with the plan or carrier  
18 with respect to the scope of services for which payment  
19 is made by the plan or carrier to the provider.

20 (c) ESSENTIAL COMMUNITY PROVIDERS DE-  
21 SCRIBED.—In this section, an “essential community pro-  
22 vider” means any of the following:

23 (1) CERTAIN MEDICARE DISPROPORTIONATE  
24 SHARE HOSPITALS.—A hospital—



1 (A) described in section  
2 1886(d)(5)(F)(i)(II) of the Social Security Act;

3 (B) described in section  
4 1886(d)(5)(F)(iv)(I) of such Act with a dis-  
5 proportionate patient percentage (as defined in  
6 section 1886(d)(5)(F)(vi) of such Act) greater  
7 than 20.2; or

8 (C) that would be described in subpara-  
9 graph (A) or (B) if the hospital were a sub-  
10 section (d) hospital (as defined in section  
11 1886(d)(1)(B) of such Act).

12 (2) SOLE COMMUNITY HOSPITALS.—A sole com-  
13 munity hospital (as described in section  
14 1886(d)(5)(D)(iii) of such Act).

15 (3) MEDICARE-DEPENDENT, SMALL RURAL  
16 HOSPITALS.—A medicare-dependent, small rural  
17 hospital (as described in section 1886(d)(5)(G)(iii)  
18 of such Act), or a hospital that would be a medicare-  
19 dependent, small rural hospital if the hospital were  
20 a subsection (d) hospital (as defined in section  
21 1886(d)(1)(B) of such Act).

22 (4) FEDERALLY QUALIFIED HEALTH CEN-  
23 TERS.—A Federally qualified health center (as de-  
24 fined in section 1861(aa)(4) of the Social Security  
25 Act) or an entity that would be such a center but

1 for its failure to meet the requirement described in  
2 section 329(f)(2)(G)(i) of the Public Health Service  
3 Act or the requirement described in section  
4 330(e)(3)(G)(i) of such Act (relating to the composi-  
5 tion of the entity's governing board).

6 (5) RURAL HEALTH CLINICS.—A rural health  
7 clinic (as defined in section 1861(aa)(2) of the So-  
8 cial Security Act).

9 (6) LOCAL HEALTH DEPARTMENTS.—A health  
10 department of a unit of State or local government  
11 which provides health services directly to individuals.

12 (7) CERTAIN CHILDREN'S HOSPITALS.—A hos-  
13 pital whose inpatients are predominantly individuals  
14 under 18 years of age and that would be described  
15 in subparagraph (A) or (B) of paragraph (1) if the  
16 hospital were a subsection (d) hospital (as defined in  
17 section 1886(d)(1)(B) of the Social Security Act)  
18 with more than 100 beds.

19 (d) SUNSET.—The requirement of subsection (a)  
20 shall not apply to health coverage provided after December  
21 31, 1999.

22 **SEC. 1014. MEDICAL SAVINGS ACCOUNTS.**

23 (a) IN GENERAL.—Chapter 79 of the Internal Reve-  
24 nue Code of 1986 is amended by adding at the end the  
25 following new section:

1 **“SEC. 7705. MEDICAL SAVINGS ACCOUNTS.**

2       “(a) GENERAL RULE.—For purposes of this title, the  
3 term ‘medical savings account’ means a trust created or  
4 organized in the United States for the exclusive benefit  
5 of an individual or his beneficiaries, but only if the written  
6 instrument creating the trust meets the following require-  
7 ments:

8               “(1) Except in the case of a rollover contribu-  
9 tion described in subsection (d)(3), no contribution  
10 will be accepted unless—

11                       “(A) it is in cash, and

12                       “(B) such individual is an eligible employee  
13 for the period for which such contribution is  
14 made.

15               “(2) The trustee is a bank (as defined in sec-  
16 tion 408(n)), insurance company (as defined in sec-  
17 tion 816), or such other person who demonstrates to  
18 the satisfaction of the Secretary that the manner in  
19 which such other person will administer the trust  
20 will be consistent with the requirements of this sec-  
21 tion.

22               “(3) No part of the trust funds will be invested  
23 in life insurance contracts.

24               “(4) The interest of an individual in the bal-  
25 ance of the account is nonforfeitable.

1           “(5) The assets of the trust will not be commin-  
2           gled with other property except in a common trust  
3           fund or common investment fund.

4           “(b) ELIGIBLE EMPLOYEE.—For purposes of this  
5           section—

6           “(1) IN GENERAL.—The term ‘eligible em-  
7           ployee’ means any employee who has high-deductible  
8           coverage (as defined in section 1103 of the Biparti-  
9           san Health Care Reform Act of 1994) offered by the  
10          employer.

11          “(2) EXCEPTION.—An employee shall be treat-  
12          ed as not being an eligible employee for any calendar  
13          year if, for any month during such year, it is reason-  
14          ably expected that such employee—

15                 “(A) will have adjusted gross income that  
16                 is less than 100 percent of the income official  
17                 poverty line (as determined by the Director of  
18                 the Office of Management and Budget) for a  
19                 family of the size involved; or

20                 “(B) is an AFDC recipient or SSI recipi-  
21                 ent.

22          “(3) DEFINITIONS.—For purposes of paragraph  
23          (2)—

24                 “(A) AFDC RECIPIENT.—The term  
25                 ‘AFDC recipient’ means, for a month, an indi-

vidual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

“(B) SSI RECIPIENT.—The term ‘SSI recipient’ means, for a month, an individual—

“(i) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

“(ii) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66 for the month,

“(iii) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

“(iv) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

“(c) TAX TREATMENT OF ACCOUNTS.—

1 “(1) ACCOUNT TAXED AS GRANTOR TRUST.—

2 “(A) IN GENERAL.—Except as provided in  
3 subparagraph (B), the account beneficiary of a  
4 medical savings account shall be treated for  
5 purposes of this title as the owner of such ac-  
6 count and shall be subject to tax thereon in ac-  
7 cordance with subpart E of part I of subchapter  
8 J of this chapter (relating to grantors and oth-  
9 ers treated as substantial owners).

10 “(B) TREATMENT OF CAPITAL LOSSES.—

11 With respect to assets held in a medical savings  
12 account, any capital loss for a taxable year  
13 from the sale or exchange of such an asset shall  
14 be allowed only to the extent of capital gains  
15 from such assets for such taxable year. Any  
16 capital loss which is disallowed under the pre-  
17 ceding sentence shall be treated as a capital  
18 loss from the sale or exchange of such an asset  
19 in the next taxable year. For purposes of this  
20 subparagraph, all medical savings accounts of  
21 the account beneficiary shall be treated as 1 ac-  
22 count.

23 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-  
24 GAGES IN PROHIBITED TRANSACTION.—

1           “(A) IN GENERAL.—If, during any taxable  
2           year of the account beneficiary, such beneficiary  
3           engages in any transaction prohibited by section  
4           4975 with respect to the account, the account  
5           shall cease to be a medical savings account as  
6           of the first day of such taxable year.

7           “(B) ACCOUNT TREATED AS DISTRIBUTING  
8           ALL ITS ASSETS.—In any case in which any ac-  
9           count ceases to be a medical savings account by  
10          reason of subparagraph (A) on the first day of  
11          any taxable year, subsection (d) shall be applied  
12          as if—

13               “(i) there were a distribution on such  
14               first day in an amount equal to the fair  
15               market value (on such first day) of all as-  
16               sets in the account (on such first day), and

17               “(ii) no portion of such distribution  
18               were used to pay qualified medical ex-  
19               penses.

20          “(3) EFFECT OF PLEDGING ACCOUNT AS SECU-  
21          RITY.—If, during any taxable year, the account ben-  
22          eficiary uses the account or any portion thereof as  
23          security for a loan, the portion so used is treated as  
24          distributed and not used to pay qualified medical ex-  
25          penses.

1       “(d) TAX TREATMENT OF DISTRIBUTIONS.—

2               “(1) INCLUSION OF AMOUNTS NOT USED FOR  
3       QUALIFIED MEDICAL EXPENSES.—

4               “(A) IN GENERAL.—Any amount paid or  
5       distributed out of a medical savings account  
6       which is not used exclusively to pay the quali-  
7       fied medical expenses of the account beneficiary  
8       or of the spouse or dependents (as defined in  
9       section 152) of such beneficiary shall be in-  
10      cluded in the gross income of such beneficiary  
11      to the extent such amount does not exceed the  
12      excess of—

13              “(i) the aggregate contributions to  
14      such account which were not includible in  
15      gross income by reason of section 106(2),  
16      over

17              “(ii) the aggregate prior payments or  
18      distributions from such account which were  
19      includible in gross income under this para-  
20      graph.

21              “(B) SPECIAL RULES.—For purposes of  
22      subparagraph (A)—

23              “(i) all medical savings accounts of  
24      the account beneficiary shall be treated as  
25      1 account,



1           “(ii) all payments and distributions  
2           during any taxable year shall be treated as  
3           1 distribution, and

4           “(iii) any distribution of property  
5           shall be taken into account at its fair mar-  
6           ket value on the date of the distribution.

7           “(2) PENALTY FOR DISTRIBUTIONS NOT USED  
8           FOR QUALIFIED MEDICAL EXPENSES.—

9           “(A) IN GENERAL.—The tax imposed by  
10          chapter 1 on the account beneficiary for any  
11          taxable year in which there is a payment or dis-  
12          tribution from a medical savings account of  
13          such beneficiary which is includible in gross in-  
14          come under paragraph (1) shall be increased by  
15          100 percent of the amount which is so includ-  
16          ible.

17          “(B) EXCEPTION FOR DISTRIBUTIONS  
18          AFTER AGE 65.—Subparagraph (A) shall not  
19          apply to any payment or distribution after the  
20          date on which the account beneficiary attains  
21          age 65.

22          “(C) EXCEPTION FOR DISABILITY OR  
23          DEATH.—Subparagraph (A) shall not apply if  
24          the payment or distribution is made after the

1 account beneficiary becomes disabled within the  
2 meaning of section 72(m)(7) or dies.

3 “(3) ROLLOVER CONTRIBUTION.—An amount is  
4 described in this paragraph as a rollover contribu-  
5 tion if it meets the requirements of subparagraphs  
6 (A) and (B).

7 “(A) IN GENERAL.—Paragraph (1) shall  
8 not apply to any amount paid or distributed  
9 from a medical savings account to the account  
10 beneficiary to the extent the amount received is  
11 paid into a medical savings account for the ben-  
12 efit of such beneficiary not later than the 60th  
13 day after the day on which he receives the pay-  
14 ment or distribution.

15 “(B) LIMITATION.—This paragraph shall  
16 not apply to any amount described in subpara-  
17 graph (A) received by an individual from a  
18 medical savings account if, at any time during  
19 the 1-year period ending on the day of such re-  
20 ceipt, such individual received any other amount  
21 described in subparagraph (A) from a medical  
22 savings account which was not includible in his  
23 gross income because of the application of this  
24 paragraph.

1           “(4) COORDINATION WITH MEDICAL EXPENSE  
2 DEDUCTION.—For purposes of section 213, any pay-  
3 ment or distribution out of a medical savings ac-  
4 count for qualified medical expenses shall not be  
5 treated as an expense paid for medical care to the  
6 extent of the amount of such payment or distribu-  
7 tion which is excludable from gross income solely by  
8 reason of paragraph (1)(A).

9           “(e) DEFINITIONS.—For purposes of this section—  
10           “(1) QUALIFIED MEDICAL EXPENSES.—The  
11 term ‘qualified medical expenses’ means any expense  
12 for medical care (as defined in section 213(d)); ex-  
13 cept that such term shall not include any amount  
14 paid for insurance.

15           “(2) ACCOUNT BENEFICIARY.—The term ‘ac-  
16 count beneficiary’ means the individual for whose  
17 benefit the medical savings account is maintained.

18           “(f) CUSTODIAL ACCOUNTS.—For purposes of this  
19 section, a custodial account shall be treated as a trust if—

20           “(1) the assets of such account are held by a  
21 bank (as defined in section 408(n)), insurance com-  
22 pany (as defined in section 816), or another person  
23 who demonstrates to the satisfaction of the Sec-  
24 retary that the manner in which he will administer

1 the account will be consistent with the requirements  
2 of this section, and

3 “(2) the custodial account would, except for the  
4 fact that it is not a trust, constitute a medical sav-  
5 ings account described in subsection (a).

6 For purposes of this title, in the case of a custodial ac-  
7 count treated as a trust by reason of the preceding sen-  
8 tence, the custodian of such account shall be treated as  
9 the trustee thereof.

10 “(g) REPORTS.—The trustee of a medical savings ac-  
11 count shall keep such records and make such reports re-  
12 garding such account to the Secretary and to the account  
13 beneficiary with respect to contributions, distributions,  
14 and such other matters as the Secretary may require  
15 under regulations. The reports required by this subsection  
16 shall be filed at such time and in such manner and fur-  
17 nished to such individuals at such time and in such man-  
18 ner as may be required by such regulations.”

19 (b) INCOME AND EMPLOYMENT TAX TREATMENT OF  
20 EMPLOYER CONTRIBUTIONS.—

21 (1) EMPLOYER PAYMENTS EXCLUDED FROM  
22 GROSS INCOME.—The text of section 106 of such  
23 Code is amended to read as follows:

24 “Gross income of an employee does not include—

1           “(1) employer-provided coverage under an acci-  
2           dent or health plan, and

3           “(2) employer contributions to any medical sav-  
4           ings account (as defined in section 7705) of an eligi-  
5           ble employee, but only to the extent that the amount  
6           contributed does not exceed the excess of premium  
7           for standard coverage over the premium for high-de-  
8           ductible coverage (as such terms are defined in sec-  
9           tion 1903 of the Bipartisan Health Care Reform Act  
10          of 1994).”

11           (2) EMPLOYER PAYMENTS EXCLUDED FROM  
12          EMPLOYMENT TAX BASE.—

13           (A) SOCIAL SECURITY TAXES.—

14           (i) Subsection (a) of section 3121 of  
15           such Code is amended by striking “or” at  
16           the end of paragraph (20), by striking the  
17           period at the end of paragraph (21) and  
18           inserting “; or”, and by inserting after  
19           paragraph (21) the following new para-  
20           graph:

21           “(22) any payment made to or for the benefit  
22           of an employee if at the time of such payment it is  
23           reasonable to believe that the employee will be able  
24           to exclude such payment from income under section  
25           106(2).”

1                   (ii) Subsection (a) of section 209 of  
2                   the Social Security Act is amended by  
3                   striking “or” at the end of paragraph (18),  
4                   by striking the period at the end of para-  
5                   graph (19) and inserting “; or”, and by in-  
6                   serting after paragraph (19) the following  
7                   new paragraph:

8                   “(20) any payment made to or for the benefit  
9                   of an employee if at the time of such payment it is  
10                  reasonable to believe that the employee will be able  
11                  to exclude such payment from income under section  
12                  106(2) of the Internal Revenue Code of 1986.”

13                  (B) RAILROAD RETIREMENT TAX.—Sub-  
14                  section (e) of section 3231 of such Code is  
15                  amended by adding at the end the following  
16                  new paragraph:

17                  “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
18                  TIONS.—The term ‘compensation’ shall not include  
19                  any payment made to or for the benefit of an em-  
20                  ployee if at the time of such payment it is reason-  
21                  able to believe that the employee will be able to ex-  
22                  clude such payment from income under section  
23                  106(2).”

24                  (C) UNEMPLOYMENT TAX.—Subsection (b)  
25                  of section 3306 of such Code is amended by

1           striking “or” at the end of paragraph (15), by  
2           striking the period at the end of paragraph (16)  
3           and inserting “; or”, and by inserting after  
4           paragraph (16) the following new paragraph:

5           “(17) any payment made to or for the benefit  
6           of an employee if at the time of such payment it is  
7           reasonable to believe that the employee will be able  
8           to exclude such payment from income under section  
9           106(2).”

10           (D) WITHHOLDING TAX.—Subsection (a)  
11           of section 3401 of such Code is amended by  
12           striking “or” at the end of paragraph (19), by  
13           striking the period at the end of paragraph (20)  
14           and inserting “; or”, and by inserting after  
15           paragraph (20) the following new paragraph:

16           “(21) any payment made to or for the benefit  
17           of an employee if at the time of such payment it is  
18           reasonable to believe that the employee will be able  
19           to exclude such payment from income under section  
20           106(2).”

21           (c) TECHNICAL AMENDMENTS.—

22           (1) TAX ON PROHIBITED TRANSACTIONS.—Sec-  
23           tion 4975 of such Code (relating to prohibited trans-  
24           actions) is amended—

1 (A) by adding at the end of subsection (c)  
2 the following new paragraph:

3 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
4 COUNTS.—An individual for whose benefit a medical  
5 savings account (within the meaning of section  
6 7705) is established shall be exempt from the tax  
7 imposed by this section with respect to any trans-  
8 action concerning such account (which would other-  
9 wise be taxable under this section) if, with respect  
10 to such transaction, the account ceases to be a medi-  
11 cal savings account by reason of the application of  
12 section 7705(c)(2)(A) to such account.”, and

13 (B) by inserting “or a medical savings ac-  
14 count described in section 7705” in subsection  
15 (e)(1) after “described in section 408(a)”.

16 (2) FAILURE TO PROVIDE REPORTS ON MEDI-  
17 CAL SAVINGS ACCOUNTS.—Section 6693 of such  
18 Code (relating to failure to provide reports on indi-  
19 vidual retirement account or annuities) is amend-  
20 ed—

21 (A) by inserting “**OR ON MEDICAL SAV-**  
22 **INGS ACCOUNTS**” after “**ANNUITIES**” in the  
23 heading of such section, and

24 (B) by adding at the end of subsection (a)  
25 the following: “The person required by section



1           7705(g) to file a report regarding a medical  
2           savings account at the time and in the manner  
3           required by such section shall pay a penalty of  
4           \$50 for each failure unless it is shown that  
5           such failure is due to reasonable cause.”

6           (3) CLERICAL AMENDMENTS.—

7                   (A) The table of sections for chapter 79 of  
8           such Code is amended by adding at the end the  
9           following:

          “Sec. 7705. Medical savings accounts.”

10                   (B) The table of sections for subchapter B  
11           of chapter 68 of such Code is amended by in-  
12           serting “or on medical savings accounts” after  
13           “annuities” in the item relating to section  
14           6693.

15           (d) EFFECTIVE DATE.—The amendments made by  
16           this section shall apply to taxable years beginning after  
17           December 31, 1996.

### 18           **PART 3—FAIR RATING PRACTICES**

#### 19           **SEC. 1021. USE OF FAIR RATING PRACTICES.**

20           (a) USE OF FAIR RATING PRACTICES.—The pre-  
21           mium rate established by a carrier for health insurance  
22           coverage in the individual/small group market (including  
23           the premium rate for coverage for a small employer  
24           through a multiple employer welfare arrangement that is  
25           fully-insured) may not vary except by the following:

1           (1) AGE.—By age, based on classes of age es-  
2           tablished by the Secretary, in consultation with the  
3           NAIC, consistent with subsection (b).

4           (2) GEOGRAPHIC AREA.—By geographic area,  
5           as identified by a State consistent with subsection  
6           (c).

7           (3) FAMILY CLASS.—By family class, based on  
8           the following 4 classes of family coverage: individual,  
9           individual with one or more children, married couple  
10          without a child, and married couple with one or  
11          more children.

12          (4) BENEFIT DESIGN.—By benefit design of  
13          coverage, including by type of coverage, such as  
14          standard coverage and high-deductible coverage, and  
15          by type of coverage option (described in section  
16          1903(15)) with respect to standard coverage.

17          (5) ADMINISTRATIVE CATEGORIES.—By per-  
18          mitted expense category, based on differences in ex-  
19          penses among such categories, consistent with sub-  
20          section (d).

21          The premiums shall be established for the different benefit  
22          designs (including standard coverage and high-deductible  
23          coverage) based on the actuarial value of the coverage for  
24          the population of the individual/small group market in the  
25          fair rating area, without regard to the distribution of such

1 population among the types of coverage or type of cov-  
2 erage options.

3 (b) LIMITATION ON VARIATION BY AGE.—

4 (1) IN GENERAL.—Any variation in premium  
5 rates by age under subsection (a)(1) for age classes  
6 of individuals under 65 years of age may not result  
7 in the ratio of the highest age rate to the lowest age  
8 rate exceeding the limiting ratio described in para-  
9 graph (2).

10 (2) LIMITING RATIO.—For purposes of para-  
11 graph (1), the limiting ratio described in this para-  
12 graph is—

13 (A) 4-to-1, for premiums for months in  
14 1997,

15 (B) 3.67-to-1, for premiums for months in  
16 1998,

17 (C) 3.33-to-1, for premiums for months in  
18 1999, and

19 (D) 3-to-1, for premiums for months in  
20 2000 and any succeeding year.

21 (3) SEPARATE AGE CLASSES FOR INDIVIDUALS  
22 65 YEARS OF AGE OR OLDER.—The Secretary shall  
23 establish one or more separate age classes for indi-  
24 viduals 65 years of age or older.

1           (4) PREEMPTION.—For preemption of State  
2       laws relating to establishment of premium rates, see  
3       section 6105.

4           (c) GEOGRAPHIC AREA VARIATIONS.—For purposes  
5       of subsection (a)(2), a State—

6           (1) may not identify an area that divides a 3-  
7       digit zip code, a county, or all portions of a metro-  
8       politan statistical area,

9           (2) shall not permit premium rates for coverage  
10       offered in a portion of an interstate metropolitan  
11       statistical area to vary based on the State in which  
12       the coverage is offered, and

13          (3) may, upon agreement with one or more ad-  
14       jacent States, identify multi-state geographic areas  
15       consistent with paragraphs (1) and (2).

16          (d) ADMINISTRATIVE VARIATIONS.—

17          (1) EXPENSE CATEGORIES.—Expense cat-  
18       egories shall be established under subsection (a)(5)  
19       by a carrier in a manner that only reflects dif-  
20       ferences based on marketing, commissions, and simi-  
21       lar expenses. Such categories shall take into account  
22       health plan purchasing organizations.

23          (2) LIMITATION ON VARIATIONS.—The vari-  
24       ation provided among expense categories under sub-  
25       section (a)(5) may not result in a premium for the

1 highest expense category exceeding 120 percent of  
2 the premium for the lowest expense category.

3 (e) PREMIUM RATING IN GROUP HEALTH PLANS.—

4 The premium rate established under a group health plan  
5 for health insurance coverage may not vary within a bene-  
6 fit design except by the factors described in subsection (a)  
7 and subject to the limitation specified in subsection (b).

8 (f) ACTUARIAL CERTIFICATION.—Each carrier that  
9 offers health insurance coverage in a State shall file annu-  
10 ally with the State commissioner of insurance a written  
11 statement by a member of the American Academy of Actu-  
12 aries (or other individual acceptable to the commissioner)  
13 that, based upon an examination by the individual which  
14 includes a review of the appropriate records and of the  
15 actuarial assumptions of the carrier and methods used by  
16 the carrier in establishing premium rates for applicable  
17 health insurance coverage—

18 (1) the carrier is in compliance with the appli-  
19 cable provisions of this section, and

20 (2) the rating methods are actuarially sound.

21 Each such carrier shall retain a copy of such statement  
22 for examination at its principal place of business.

23 (g) CONSTRUCTION.—The provisions of this section  
24 shall apply to premium rates established by carriers for  
25 multiple employer welfare arrangements that are fully-in-

1   sured or for fully-insured coverage offered with respect to  
2   individuals and small employers in the individual/small  
3   group market. Such premium rates shall apply based on  
4   the fair rating area in which the covered individual or em-  
5   ployee resides to reflect the population in the individual/  
6   small group market.

7   **SEC. 1022. COORDINATION WITH PREMIUM ASSISTANCE**  
8                   **CERTIFICATE PROGRAM.**

9           Each carrier or group health plan providing qualified  
10   health coverage shall accept and apply (as a reduction  
11   against premiums otherwise imposed) any premium cer-  
12   tificate issued under a State premium assistance program  
13   under part A of title XXI of the Social Security Act.

14   **SEC. 1023. ESTABLISHMENT OF RISK ADJUSTMENT MECHA-**  
15                   **NISMS.**

16           (a) ESTABLISHMENT OF STANDARDS.—

17                   (1) DEVELOPMENT OF MODELS.—

18                           (A) IN GENERAL.—The Secretary shall re-  
19                   quest the NAIC to develop, within 9 months  
20                   after the date of the enactment of this Act and  
21                   in consultation with the American Academy of  
22                   Actuaries, a model risk adjustment system com-  
23                   posed of one or more risk adjustment mecha-  
24                   nisms under which premiums applicable to  
25                   health insurance coverage in the individual/

1 small group market and coverage under small  
2 employer pooling arrangements and under mul-  
3 tiple employer welfare arrangements that are  
4 fully insured (without regard to whether such  
5 an arrangement is offered through an associa-  
6 tion) would be adjusted to take into account  
7 such factors as may be appropriate to predict  
8 the future need and the efficient use of services  
9 by covered individuals in the market. Such fac-  
10 tors may include the age, gender, geographic  
11 residence, health status, or other demographic  
12 characteristics of individuals enrolled in such  
13 plans and shall include consideration of enroll-  
14 ment of a disproportionate share of individuals  
15 who enroll during the initial open enrollment  
16 period under section 1005(b)(1).

17 (B) PROMULGATION AS PROPOSED  
18 RULE.—If the NAIC develops such model with-  
19 in such period, the Secretary shall publish the  
20 model as a proposed rule under section 553 of  
21 title 5, United States Code. If the NAIC has  
22 not developed such model within such period,  
23 the Secretary shall publish (not later than 60  
24 days after the end of such period) a proposed

1 rule that specifies a proposed model that pro-  
2 vides for effective risk adjustment mechanisms.

3 (2) RULE MAKING PROCESS.—The Secretary  
4 shall provide for a period (described in section  
5 553(c) of title 5, United States Code) of not less  
6 than 30 days for public comment on a proposed rule  
7 published under paragraph (1)(B). The Secretary  
8 shall publish a final rule, by not later than January  
9 1, 1996, that specifies risk adjustment mechanisms  
10 that the Secretary finds are effective for purposes of  
11 carrying out this section. Such rule shall include  
12 models developed by the NAIC if the Secretary finds  
13 that such models provide for effective risk adjust-  
14 ment mechanisms.

15 (3) MODIFICATION.—The Secretary, at the re-  
16 quest of the NAIC or otherwise, may by regulation  
17 modify the model risk adjustment system established  
18 under this subsection.

19 (b) IMPLEMENTATION OF RISK ADJUSTMENT SYS-  
20 TEM.—Each State shall establish and maintain a risk ad-  
21 justment system that conforms with the model established  
22 under this section by not later than January 1, 1997. A  
23 State may establish and maintain such a system jointly  
24 with one or more other States.



1       (c) APPLICATION TO SMALL EMPLOYER POOLING  
2 ARRANGEMENTS AND FULLY-INSURED MEWAs.—As re-  
3 quired under sections 704(b)(6)(B) and 711(c)(1)(B) of  
4 the Employee Retirement Income Security Act of 1974,  
5 as added by section 1401 of this Act, this section applies  
6 to small employer pooling arrangements and to multiple  
7 employer welfare arrangements that are fully insured  
8 (without regard to whether such an arrangement is offered  
9 through an association), with respect to individuals cov-  
10 ered in the individual/small employer market, in such form  
11 and manner as the Secretary of Labor prescribes in regu-  
12 lation, in consultation with the Secretary of Health and  
13 Human Services. In applying this section to a small em-  
14 ployer pooling arrangement, the regulation shall provide  
15 that assessments and credits under this section shall be  
16 provided through coordination with an insurer that pro-  
17 vides excess/stop loss coverage (as defined in section 701  
18 of such Act) with respect to the arrangement.

19               **PART 4—CONSUMER PROTECTIONS**

20       **SEC. 1031. REQUIREMENT FOR PROVISION OF INFORMA-**  
21               **TION.**

22       (a) CARRIERS.—

23               (1) IN GENERAL.—Each carrier that offers  
24 health insurance coverage to small employers (or eli-  
25 gible employees of small employers) or qualifying in-

1 individuals must disclose to such prospective enrollees,  
2 to brokers, and to health plan purchasing organiza-  
3 tions the information that the Secretary may specify  
4 relating to the performance of the carrier in provid-  
5 ing such coverage, consistent with any quality meas-  
6 ures established under section 5002, and relating to  
7 differences between the coverage provided and the  
8 most similar model benefit package established  
9 under section 1104(b)(2). If a carrier offers to indi-  
10 viduals or employers coverage the actuarial value of  
11 which is more than the actuarial value for high-de-  
12 ductible coverage but less than such value for stand-  
13 ard coverage, the carrier must disclose to such em-  
14 ployers or individuals detailed information on how  
15 the coverage offered compares to any standard and  
16 high-deductible coverage offered by the carrier to  
17 such individuals and employers.

18 (2) **MARKETING MATERIAL.**—Each carrier that  
19 provides any health insurance coverage in a State  
20 shall file with the State those marketing materials  
21 relating to the offer and sale of health insurance  
22 coverage to be used for distribution before the mate-  
23 rials are used. Such materials shall be in a uniform  
24 format specified under the standards established  
25 under section 1301.

1       (b) GROUP HEALTH PLANS.—Each group health  
2 plan that provides health coverage must disclose to enroll-  
3 ees and potential enrollees information, similar to the in-  
4 formation described in subsection (a), relating to perform-  
5 ance of the plan in providing such coverage, consistent  
6 with any quality measures established under section 5002,  
7 and relating to differences between the coverage provided  
8 and the most similar model benefit package established  
9 under section 1104(b)(2).

10       (c) INFORMATION RELATING TO RISK ADJUST-  
11 MENT.—Each carrier or group health plan providing cov-  
12 erage in the individual/small group market (including  
13 small employer pooling arrangements and certified mul-  
14 tiple employer health plans that are fully insured, without  
15 regard to whether such an arrangement or plan is offered  
16 through an association) shall provide to the State such in-  
17 formation as the State may require in order to carry out  
18 section 1023 (relating to risk adjustment mechanisms).

19 **SEC. 1032. PROHIBITION OF IMPROPER INCENTIVES.**

20       (a) LIMITATION ON FINANCIAL INCENTIVES.—No  
21 carrier that provides health insurance coverage may vary  
22 the commission or financial or other remuneration to a  
23 person based on the claims experience or health status of  
24 individuals enrolled by or through the person.

1 (b) NONDISCRIMINATION IN AGENT COMPENSA-  
2 TION.—A carrier—

3 (1) may not vary or condition the compensation  
4 provided to an agent or broker related to the sale or  
5 renewal of health insurance coverage because of the  
6 health status or claims experience of any individuals  
7 enrolled with the carrier through the agent or  
8 broker; and

9 (2) may not terminate, fail to renew, or limit its  
10 contract or agreement of representation with an  
11 agent or broker for any reason related to the health  
12 status or claims experience of any individuals en-  
13 rolled with the carrier through the agent or broker.

14 (c) PROHIBITION OF TIE-IN ARRANGEMENTS.—No  
15 carrier that offers health insurance coverage may require  
16 the purchase of any other insurance or product as a condi-  
17 tion for the purchase of such coverage.

18 **SEC. 1033. WRITTEN POLICIES AND PROCEDURES RESPECT-**  
19 **ING ADVANCE DIRECTIVES.**

20 A carrier and a group health plan offering health cov-  
21 erage shall meet the requirements of section 1866(f) of  
22 the Social Security Act (relating to maintaining written  
23 policies and procedures respecting advance directives), in-  
24 sofar as such requirements would apply to the carrier or  
25 plan if the carrier or plan were an eligible organization.

## Subtitle B—Benefits

### 2 SEC. 1101. QUALIFIED HEALTH COVERAGE.

3 In this Act, the term “qualified health coverage”  
4 means health coverage that—

5 (1) provides—

6 (A) standard coverage consistent with sec-  
7 tion 1102(a), or

8 (B) high-deductible coverage consistent  
9 with section 1103; and

10 (2) meets other requirements of subtitle A ap-  
11 plicable to the coverage and the carrier or group  
12 health plan providing the coverage.

### 13 SEC. 1102. STANDARD COVERAGE.

14 (a) IN GENERAL.—Health insurance coverage is con-  
15 sidered to provide standard coverage consistent with this  
16 subsection and for preventive benefits under subsection  
17 (b)(4) if—

18 (1) benefits under such coverage are provided  
19 within at least each of the required categories of  
20 benefits described in paragraph (1) of subsection (b)  
21 and consistent with such subsection;

22 (2) the actuarial value of the benefits meets the  
23 requirements of subsection (c), and

24 (3) the benefits comply with the minimum re-  
25 quirements specified in subsection (d).

1       (b) REQUIRED CATEGORIES OF COVERED BENE-  
2     FITS.—

3           (1) IN GENERAL.—The categories of covered  
4     benefits described in this paragraph are the types of  
5     benefits specified in each of subparagraphs (A), (B),  
6     (C), (D), (E), and (F) of paragraph (1), and sub-  
7     paragraphs (E) and (F) of paragraph (2), of section  
8     8904(a) of title 5, United States Code (relating to  
9     types of benefits required to be in health insurance  
10    offered to Federal employees).

11          (2) COVERAGE OF TREATMENTS IN APPROVED  
12     RESEARCH TRIALS.—

13           (A) IN GENERAL.—Coverage of the routine  
14     medical costs (as defined in subparagraph (B))  
15     associated with the delivery of treatments shall  
16     be considered to be medically appropriate if the  
17     treatment is part of an approved research trial  
18     (as defined in subparagraph (C)).

19           (B) ROUTINE MEDICAL COSTS DEFINED.—  
20     In subparagraph (A), the term “routine medical  
21     costs” means the cost of health services re-  
22     quired to provide treatment according to the de-  
23     sign of the trial, except those costs normally  
24     paid for by other funding sources (as defined by  
25     the Secretary). Such costs do not include the

1 cost of the investigational agent, devices or pro-  
2 cedures themselves, the costs of any nonhealth  
3 services that might be required for a person to  
4 receive the treatment, or the costs of managing  
5 the research.

6 (C) APPROVED RESEARCH TRIAL DE-  
7 FINED.—In subparagraph (A), the term “ap-  
8 proved research trial” means a trial—

9 (i) conducted for the primary purpose  
10 of determining the safety, effectiveness, ef-  
11 ficacy, or health outcomes of a treatment,  
12 compared with the best available alter-  
13 native treatment, and

14 (ii) approved by the Secretary.

15 A trial is deemed to be approved under clause  
16 (ii) if it is approved by the National Institutes  
17 of Health, the Food and Drug Administration  
18 (through an investigational new drug exemp-  
19 tion), the Department of Veterans Affairs, or  
20 by a qualified nongovernmental research entity  
21 (as identified in guidelines issued by one or  
22 more of the National Institutes of Health).

23 (3) COVERAGE OF OFF-LABEL USE.—An off-  
24 label use for a drug that has been found to be safe  
25 and effective under section 505 of the Federal Food,

1 Drug, and Cosmetic Act shall be covered if the medi-  
2 cal indication for which it is used is listed in one of  
3 the following 3 compendia: the American Hospital  
4 Formulary Service-Drug Information, the American  
5 Medical Association Drug Evaluations, and the  
6 United States Pharmacopeia-Drug Information.

7 (4) PREVENTIVE BENEFITS.—The following are  
8 preventive benefits that shall be covered without any  
9 deductibles, copayment, coinsurance, or other cost-  
10 sharing:

11 (A) NEWBORN, WELL-BABY AND WELL-  
12 CHILD CARE.—Newborn care, well-baby care,  
13 and well-child care for individuals under 19  
14 years of age, including routine physical exami-  
15 nations, routine immunizations, and routine  
16 tests, as specified by the Secretary based on the  
17 schedule recommended by the American Acad-  
18 emy of Pediatricians.

19 (B) MAMMOGRAMS.—Routine screening  
20 mammograms (including their interpretation),  
21 limited to 1 mammogram for a woman who is  
22 at least 35 (but less than 40) years of age, 1  
23 mammogram every 2 years for a woman who is  
24 at least 40 (but less than 50) years of age, and



1           1 mammogram every year for a woman who is  
2           at least 50 years of age.

3           (C) SCREENING PAP SMEARS AND PELVIC  
4           EXAMS.—Screening pap smears and pelvic  
5           exams for women over 17 years of age, limited  
6           to 1 each year.

7           (D) COLORECTAL SCREENING.—Colorectal  
8           screening for individuals over 18 years of age at  
9           high risk, consisting of 1 fecal occult blood  
10          screening test every year, 1 screening  
11          sigmoidoscopy every 5 years, and 1 screening  
12          colonoscopy every 4 years.

13          (E) SCREENING TUBERCULIN TESTS.—  
14          Screening tuberculin tests annually for individ-  
15          uals at risk of contracting tuberculosis.

16          (F) PRENATAL CARE.—Prenatal care.

17          (G) ADULT IMMUNIZATIONS.—Routine im-  
18          munizations for an individual over 17 years of  
19          age (including booster immunizations against  
20          tetanus and diphtheria, but limited to 1 such  
21          immunization every 10 years).

22          (H) PROSTATE CANCER SCREENING.—  
23          Routine cancer screening for a man who is at  
24          least 40 years of age through a prostate specific  
25          antigen test, limited to 1 test each year.

1 (c) STANDARD ACTUARIAL VALUE.—

2 (1) IN GENERAL.—The actuarial value of the  
3 benefits under standard coverage in a fair rating  
4 area meets the requirements of this subsection if  
5 such value is equivalent to the standard actuarial  
6 value described in paragraph (2) for the area. The  
7 actuarial value of benefits under standard coverage  
8 shall be determined using the adjustment under  
9 paragraph (3) for a standardized population and set  
10 of standardized utilization and cost factors.

11 (2) STANDARD ACTUARIAL VALUE DE-  
12 SCRIBED.—The standard actuarial value described  
13 in this paragraph for coverage in a geographic area  
14 is the actuarial value of benchmark coverage during  
15 1994 in such area. Such actuarial value shall be de-  
16 termined using the adjustment under paragraph (3)  
17 for a standardized population and set of standard-  
18 ized utilization and cost factors and updated annu-  
19 ally in accordance with section 1104(a).

20 (3) ADJUSTMENTS FOR STANDARDIZED POPU-  
21 LATION, STANDARDIZED UTILIZATION AND COST  
22 FACTORS, AND GEOGRAPHIC AREA.—The adjustment  
23 under this paragraph—

24 (A) for a standardized population shall be  
25 made by not taking into account individuals 65

1 years of age or older, employees of the United  
2 States Postal Service, retirees, and annuitants;  
3 and

4 (B)(i) except as provided in clause (ii), for  
5 a geographic area shall be made in a manner  
6 that reflects the ratio of the actuarial value of  
7 benchmark coverage in such geographic area  
8 (as adjusted under subparagraph (A)) to such  
9 actuarial value for such benchmark coverage for  
10 the United States as a whole, taking into ac-  
11 count standardized actuarial utilization and  
12 cost factors, and

13 (ii) in the case of a group health plan oper-  
14 ating in more than one geographic area, the  
15 ratio described in clause (i) shall be determined  
16 in accordance with regulations promulgated by  
17 the Secretary.

18 At the election of a group health plan under sub-  
19 paragraph (B)(ii), the ratio under such subpara-  
20 graph shall be 1.

21 (d) MINIMUM REQUIREMENTS WITHIN A CAT-  
22 EGORY.—Benefits offered in any standard coverage within  
23 any category of benefits shall be not less than the narrow-  
24 est scope and shortest duration of benefits within that cat-  
25 egory in any of the approved health benefits plans offered

1 under chapter 89 of title 5, United States Code (relating  
2 to Federal Employees Health Benefits Program) in 1994.  
3 Benefits offered in the standard plan within the category  
4 of preventive services shall not require payment of cost-  
5 sharing for covered items and services.

6 (e) NO COVERAGE OF SPECIFIC TREATMENT, PRO-  
7 CEDURES, OR CLASSES REQUIRED.—Nothing in this sec-  
8 tion (or section 1103) may be construed to require the  
9 coverage of any specific procedure or treatment or class  
10 of service in health coverage under this Act or through  
11 regulation.

12 (f) CONSTRUCTION.—Nothing in this section (or sec-  
13 tion 1103) shall be construed as requiring coverage to in-  
14 clude benefits for items and services that are not medically  
15 necessary or appropriate.

16 **SEC. 1103. HIGH-DEDUCTIBLE COVERAGE.**

17 Health insurance coverage is considered to provide  
18 high-deductible coverage consistent with this section if—

19 (1) benefits under such coverage comply with—

20 (A) the requirements described in section  
21 1102(b) (relating to required categories of cov-  
22 ered benefits), and

23 (B) the requirements described in section  
24 1102(d) (relating to minimum requirements  
25 within a category);

1           (2) the deductible amount is the amount estab-  
2       lished under section 1104(b)(1);

3           (3) benefits under the coverage in any year  
4       (other than preventive benefits described in section  
5       1102(b)(4)) are covered only to the extent expenses  
6       incurred for items and services included in the cov-  
7       erage for the year exceed the deductible amount  
8       specified in paragraph (2); and

9           (4) the actuarial value of the coverage (as de-  
10      termined under rules consistent with section  
11      1102(c)) is equivalent to 80 percent of the actuarial  
12      value established under such section for standard  
13      coverage.

14   **SEC. 1104. ACTUARIAL VALUATION OF BENEFITS.**

15       (a) IN GENERAL.—The Secretary, in consultation  
16      with the NAIC and the American Academy of Actuaries,  
17      shall establish (and may from time to time modify) proce-  
18      dures by which health insurance benefits are valued for  
19      purposes of this subtitle.

20       (b) DEDUCTIBLE; MODEL BENEFIT PACKAGES.—  
21      The Secretary, in consultation with the NAIC and the  
22      American Academy of Actuaries, shall establish—

23           (1) the deductible amount for high-deductible  
24      coverage for the purposes of section 1103(2) such  
25      that the actuarial value of high-deductible coverage

1 described in section 1103 is 20 percent less than the  
2 actuarial value of standard coverage described in  
3 section 1102(a); and

4 (2) model benefit packages that may be treated,  
5 for purposes of this title, as meeting the require-  
6 ments for standard or high-deductible coverage  
7 under sections 1102(a) and 1103, respectively, and  
8 which shall include model cost sharing arrangements  
9 for fee-for-service options, managed care options,  
10 and point-of-service options.

11 **SEC. 1105. LIMITATION ON OFFERING SUPPLEMENTAL BEN-**  
12 **EFITS.**

13 A carrier or group health plan offering qualified  
14 health coverage may offer coverage of items and services  
15 only in addition to the qualified standard coverage offered  
16 (whether in the form of coverage of additional items and  
17 services or a reduction in cost sharing) and only if—

18 (1) such supplemental coverage is offered and  
19 priced separately from the standard coverage offered  
20 and is only made available to individuals who obtain  
21 qualified standard coverage through the carrier or  
22 plan;

23 (2) the purchase of the qualified health cov-  
24 erage is not conditioned upon the purchase of such  
25 supplemental coverage; and

1           (3) in the case of supplemental coverage that  
2           consists of a reduction in the cost-sharing otherwise  
3           applicable, the premium for the supplemental cov-  
4           erage takes into account any expected increase in  
5           utilization of items and services included in the  
6           qualified health coverage resulting from obtaining  
7           the supplemental coverage.

8   **SEC. 1106. FAMILY COVERAGE OPTION; SUPPLEMENTAL**  
9                           **COVERAGE.**

10          (a) FAMILY COVERAGE OPTION.—Each carrier and  
11          group health plan that offers health insurance coverage  
12          shall provide for an option under which children under 26  
13          years of age (without regard to whether they are full-time  
14          students or disabled) will be treated (with respect to fam-  
15          ily coverage) as family members. The carrier or plan may  
16          impose an additional premium for such option.

17          (b) CONSTRUCTION.—Nothing in this title shall be  
18          construed as limiting the benefits that may be offered as  
19          part of a group health plan or health insurance coverage.

20   **SEC. 1107. LEVEL PLAYING FIELD FOR PROVIDERS.**

21          (a) IN GENERAL.—Nothing in this subtitle may be  
22          construed to require or prohibit the use of a particular  
23          class of provider, among the providers that are legally au-  
24          thorized to provide such treatment.

25          (b) COVERAGE OF CERTAIN OTHER PROVIDERS.—

1           (1) IN GENERAL.—For purposes of this sub-  
2           title, benefits under standard coverage shall include  
3           the following:

4                   (A) Coverage provided at an individual's  
5           home by a Christian Science practitioner or  
6           Christian Science nurse.

7                   (B) Coverage provided in a Christian  
8           Science Sanitorium (as defined in section  
9           1861(y) of the Social Security Act), including  
10          coverage provided by a Christian Science practi-  
11          tioner.

12          (2) QUALIFICATIONS OF PROVIDERS.—A Chris-  
13          tian Science practitioner or Christian Science nurse  
14          is qualified for purposes of paragraph (1) if the  
15          practitioner or nurse is listed as such a practitioner  
16          or nurse by the First Church of Christ, Scientist, in  
17          Boston, Massachusetts.

## 18                   **Subtitle C—Employer** 19                   **Responsibilities**

### 20   **SEC. 1201. REQUIRING EMPLOYERS TO OFFER OPTION OF** 21                   **COVERAGE.**

22          (a) IN GENERAL.—Subject to subsections (c) and (d),  
23          each employer shall make available with respect to each  
24          qualifying employee qualified health coverage under a  
25          group health plan (whether fully-insured or self-insured)



1 which meets the following requirements (and the applica-  
2 ble requirements of subtitle A):

3 (1) ANNUAL OFFERING.—The employee may  
4 elect health coverage for the employee and family  
5 members on an annual basis for each plan year and  
6 at such other times as may be specified by the Sec-  
7 retary of Labor, in a manner consistent with the  
8 standards established to carry out section 1105.

9 (2) CHOICE OF COVERAGE.—

10 (A) IN GENERAL.—Subject to subsection  
11 (c) and subparagraph (G), such coverage is pro-  
12 vided for at least—

13 (i) a competing choice of qualified  
14 standard coverage (consistent with section  
15 1102(a)), including at least one option (ei-  
16 ther a fee-for-service option or a point-of-  
17 service option) that permits covered indi-  
18 viduals to obtain benefits through an unre-  
19 stricted choice of the lawful providers for  
20 which benefits are made available; and

21 (ii) high-deductible coverage (consist-  
22 ent with section 1103).

23 (B) COVERAGE FLOOR.—With respect to  
24 any health coverage (other than coverage for

1 supplemental benefits or qualified standard cov-  
2 erage) offered under the group health plan—

3 (i) the coverage shall meet the re-  
4 quirements specified in paragraphs (1) and  
5 (3) of section 1102(a), and

6 (ii) the actuarial value of such cov-  
7 erage shall not be less than the actuarial  
8 value of high-deductible coverage.

9 (C) DISCLOSURE FOR CERTAIN COV-  
10 ERAGE.—If an employer offers, in addition to  
11 the coverage required to be offered under sub-  
12 paragraph (A), coverage the actuarial value of  
13 which is more than the actuarial value for high-  
14 deductible coverage but less than such value for  
15 standard coverage, the employer must disclose  
16 to the employees detailed information on how  
17 the coverage offered compares to the standard  
18 and high-deductible coverage offered by the em-  
19 ployer.

20 (D) USE OF STANDARDIZED FACTORS.—  
21 For purposes of this paragraph, the actuarial  
22 value of coverage shall be determined using the  
23 standardized population and standardized utili-  
24 zation and cost factors described in section  
25 1102(c)(3).

1           (E) FAMILY COVERAGE OPTION.—The  
2           offer of coverage under this section with respect  
3           to a qualifying employee shall include the option  
4           of coverage of family members of the employee.

5           (F) ANNUAL ENROLLMENT PERIOD FOR  
6           CHOICE OF COVERAGE.—The group health plan  
7           provides, with respect to any qualifying em-  
8           ployee, a single annual open enrollment period  
9           (of not less than 30 days) in which the em-  
10          ployee may choose among the coverage options  
11          required under this paragraph.

12          (G) LIMITATION ON OFFER OF HIGH-DE-  
13          DUCTIBLE COVERAGE.—Qualified high-deduct-  
14          ible coverage may not be made available under  
15          a group health plan with respect to an employee  
16          unless the employee demonstrates to the plan  
17          administrator that the employee has available  
18          assets (as defined by the Secretary) equal to at  
19          least the deductible amount established under  
20          section 1104(b)(1) applicable to the high-de-  
21          ductible coverage.

22          (3) PAYROLL WITHHOLDING.—The employee  
23          electing such coverage may elect to have any pre-  
24          miums owed by the employee collected through pay-  
25          roll deduction.

1           (4) NONDISCRIMINATION IN CONTRIBUTIONS  
2       BASED ON PRICE OF COVERAGE SELECTED WITH RE-  
3       SPECT TO INDIVIDUAL EMPLOYEES.—

4           (A) IN GENERAL.—The employer may not  
5       vary the dollar amount of any employer con-  
6       tribution, within a class of family coverage, with  
7       respect to such coverage for an individual em-  
8       ployee, solely on the basis of the total premium  
9       price of the coverage selected by the employee.

10          (B) SPECIAL RULES.—In applying sub-  
11       paragraph (A)—

12           (i) the “total premium price” shall in-  
13       clude, in the case of high-deductible cov-  
14       erage, amounts paid by an employer into a  
15       medical savings account (established under  
16       section 7705 of the Internal Revenue Code  
17       of 1986); and

18           (ii) if the employee selects health cov-  
19       erage the premium for which is less than  
20       the amount of the employer contribution,  
21       the employer shall pay the amount of such  
22       difference to the employee (or, at the em-  
23       ployee’s option in the case of an employee  
24       who has high-deductible coverage, to such  
25       a medical savings account).

1       (b) NO EMPLOYER MANDATE.—Subject to subsection  
2 (a)(4) (relating to equal contribution rule), an employer  
3 is not required under this section to make any contribution  
4 to the cost of health coverage.

5       (c) GRANDFATHER FOR EXISTING COLLECTIVE BAR-  
6 GAINING AGREEMENTS.—

7           (1) IN GENERAL.—The requirement of sub-  
8 section (a)(2) shall not apply to a group health plan  
9 for a plan year if—

10           (A) the group health plan is in effect in  
11 the plan year in which July 1, 1994, occurs,  
12 and

13           (B) the employer makes (or offers to  
14 make), in such plan year and the plan year in-  
15 volved, a contribution to the plan on behalf of  
16 each employee who is eligible to participate in  
17 the plan under a collective bargaining agree-  
18 ment or similar contract.

19           (2) SUNSET.—Paragraph (1) shall only apply to  
20 a group health plan until the expiration of the collec-  
21 tive bargaining agreement or similar contract in ef-  
22 fect on the date of the enactment of this Act or, if  
23 earlier, January 1, 2000.

24       (d) SPECIAL RULES.—

1           (1) EMPLOYERS CONTRACTING WITH HEALTH  
2           PLAN PURCHASING ORGANIZATIONS, ETC.—An em-  
3           ployer is deemed to have satisfied the requirements  
4           of subsection (a) with respect to an employee if the  
5           employer enters into a contract with a health plan  
6           purchasing organization (established under subtitle  
7           A of title VI), a small employer pooling arrangement  
8           (described in section 711 of the Employee Retirement  
9           Income Security Act of 1974), a multiemployer  
10          plan providing health benefits, or a certified multiple  
11          employer health plan (as defined in section 701(9)  
12          of the Employee Retirement Income Security Act of  
13          1974) to offer coverage with respect to the employee.

14          (2) EXCLUSION OF NEW EMPLOYERS AND CER-  
15          TAIN SMALL EMPLOYERS.—Subsection (a) shall not  
16          apply to any small employer for any plan year if, as  
17          of the beginning of such plan year—

18                (A) such employer (including any prede-  
19                cessor thereof) has been an employer for less  
20                than 1 year,

21                (B) such employer has no more than 2  
22                qualifying employees, or

23                (C) no more than 2 qualifying employees  
24                of the employer are not covered under any  
25                group health plan.

1           (3) EXCLUSION OF FAMILY MEMBERS.—Under  
2       such procedures as the Secretary may prescribe, any  
3       relative of an employer may be, at the election of the  
4       employer, excluded from consideration as a qualify-  
5       ing employee for purposes of applying the require-  
6       ments of subsection (a). In the case of an employer  
7       that is not an individual, an employee who is a rel-  
8       ative of a key employee (as defined in section  
9       416(i)(1) of the Internal Revenue Code of 1986) of  
10      the employer may, at the election of the key em-  
11      ployee, be considered a relative excludable under this  
12      paragraph.

13       (e) CONSTRUCTION ON RANGE OF COVERAGE OF-  
14      FERINGS.—Nothing in this section shall be construed—

15           (1) as limiting the number of standard and  
16       high-deductible coverage options that an employer  
17       may offer to an employee,

18           (2) as preventing employers from offering sup-  
19       plemental coverage described in section 1105, or

20           (3) as preventing an employer from providing  
21       for contributions to a medical savings account in  
22       connection with the offering of high-deductible cov-  
23       erage, subject to subsection (a)(4) and the require-  
24       ments of section 7705 of the Internal Revenue Code  
25       of 1986.

1 **SEC. 1202. NONDISCRIMINATION UNDER GROUP HEALTH**  
2 **PLANS.**

3 (a) APPLICATION OF RULES SIMILAR TO MEDICARE  
4 NONDISCRIMINATION RULES.—The provisions of para-  
5 graphs (1)(A), (1)(D), (1)(E), (3)(A), and (3)(C) of sec-  
6 tion 1862(b) of the Social Security Act shall apply to a  
7 premium or cost-sharing assistance eligible individual  
8 under part A of title XXI of such Act in relation to an  
9 employer in the same manner as such provisions apply to  
10 an individual age 65 or over who is entitled to benefits  
11 under title XVIII of such Act under section 226(a) of such  
12 Act in relation to such employer.

13 (b) RULES OF APPLICATION.—In applying subsection  
14 (a)—

15 (1) in applying clauses (ii) and (iii) of section  
16 1862(b)(1)(A) of the Social Security Act, any ref-  
17 erence to “20 or more employees” is deemed a ref-  
18 erence to “5 or more employees”;

19 (2) clause (iv) of section 1862(b)(1)(A) of such  
20 Act shall not apply; and

21 (3) any reference to title XVIII of such Act is  
22 deemed a reference to assistance under part A of  
23 title XXI of such Act (as added by subtitle A of title  
24 II of this Act).

25 (c) ENFORCEMENT.—



1           (1) IN GENERAL.—Chapter 47 of the Internal  
2       Revenue Code of 1986 (relating to excise taxes on  
3       qualified pension, etc. plans) is amended by inserting  
4       after section 5000 the following new section:

5       **“SEC. 5000A. EMPLOYER REQUIREMENTS.**

6           “(a) GENERAL RULE.—There is hereby imposed a  
7       tax on the failure of any employer to comply with the re-  
8       quirements of section 1201 and section 1202 of the Bipar-  
9       tisan Health Care Reform Act of 1994.

10          “(b) AMOUNT OF TAX.—The amount of tax imposed  
11       by subsection (a) shall be equal to \$100 for each day for  
12       each individual for which such a failure occurs.

13          “(c) LIMITATION ON TAX.—

14               “(1) TAX NOT TO APPLY WHERE FAILURES  
15       CORRECTED WITHIN 30 DAYS.—No tax shall be im-  
16       posed by subsection (a) with respect to any failure  
17       if—

18                   “(A) such failure was due to reasonable  
19               cause and not to willful neglect, and

20                   “(B) such failure is corrected during the  
21               30-day period (or such period as the Secretary  
22               may determine appropriate) beginning on the  
23               1st date any of the individuals on whom the tax  
24               is imposed knew, or exercising reasonable dili-

1           gence would have known, that such failure ex-  
2           isted.

3           “(2) WAIVER BY SECRETARY.—In the case of a  
4           failure which is due to reasonable cause and not to  
5           willful neglect, the Secretary may waive part or all  
6           of the tax imposed by subsection (a) to the extent  
7           that the payment of such tax would be excessive rel-  
8           ative to the failure involved.”.

9           (2) CLERICAL AMENDMENT.—The table of sec-  
10          tions for such chapter 47 is amended by adding at  
11          the end the following new item:

          “Sec. 5000A. Employer requirements.”.

12          (3) EFFECTIVE DATE.—The amendments made  
13          by this subsection shall take effect on January 1,  
14          1997.

15   **SEC. 1203. EFFECTIVE DATES.**

16          Except as otherwise provided, the requirements of  
17          sections 1201 and 1202 shall apply to plan years begin-  
18          ning after December 31, 1996.

19   **Subtitle D—Standards and Certifi-**  
20   **cation; Enforcement; Preemp-**  
21   **tion; General Provisions**

22   **SEC. 1301. ESTABLISHMENT OF STANDARDS.**

23          (a) ROLE OF NAIC.—

1           (1) IN GENERAL.—The Secretary shall request  
2           the NAIC to develop, within 9 months after the date  
3           of the enactment of this Act, model regulations that  
4           specify standards with respect to the requirements of  
5           this subtitle as applicable to carriers and health in-  
6           surance coverage.

7           (2) REVIEW OF STANDARDS.—If the NAIC de-  
8           velops recommended regulations specifying such  
9           standards within such period, the Secretary shall re-  
10          view the standards. Such review shall be completed  
11          within 60 days after the date the regulations are de-  
12          veloped. Unless the Secretary determines within  
13          such period that the standards do not meet the re-  
14          quirements, such standards shall serve as the stand-  
15          ards under this subtitle, with such amendments as  
16          the Secretary deems necessary.

17          (b) CONTINGENCY.—If the NAIC does not develop  
18          such model regulations within such period or the Secretary  
19          determines that such regulations do not specify standards  
20          that meet the requirements described in subsection (a),  
21          the Secretary shall specify, within 15 months after the  
22          date of the enactment of this Act, standards to carry out  
23          those requirements.

1 **SEC. 1302. APPLICATION OF STANDARDS TO CARRIERS**  
2 **THROUGH STATES.**

3 (a) APPLICATION OF STANDARDS.—

4 (1) IN GENERAL.—Each State shall submit to  
5 the Secretary, by the deadline specified in paragraph  
6 (2), a report on steps the State is taking to imple-  
7 ment and enforce the standards established under  
8 section 1301 with respect to carriers and health in-  
9 surance coverage offered or renewed not later than  
10 such deadline.

11 (2) DEADLINE FOR REPORT.—The deadline  
12 under this paragraph is 1 year after the date the  
13 standards are established under section 1301.

14 (b) FEDERAL ROLE.—

15 (1) NOTICE OF DEFICIENCY.—If the Secretary  
16 determines that a State has failed to submit a report  
17 by the deadline specified under subsection (a)(2) or  
18 finds that the State has not implemented and pro-  
19 vided adequate enforcement of the standards estab-  
20 lished under section 1301, the Secretary shall notify  
21 the State and provide the State a period of 60 days  
22 in which to submit such report or to implement and  
23 enforce such standards.

24 (2) IMPLEMENTATION OF ALTERNATIVE.—

25 (A) IN GENERAL.—If, after such 60-day  
26 period, the Secretary finds that such a failure

1           has not been corrected, the Secretary shall pro-  
2           vide for such mechanism for the implementation  
3           and enforcement of such standards in the State  
4           as the Secretary determines to be appropriate.

5           (B) EFFECTIVE PERIOD.—Such implemen-  
6           tation and enforcement shall take effect with  
7           respect to carriers, and health insurance cov-  
8           erage offered or renewed, on or after 3 months  
9           after the date of the Secretary's finding under  
10          subparagraph (A), and until the date the Sec-  
11          retary finds that such a failure has been cor-  
12          rected.

13   **SEC. 1303. APPLICATION TO GROUP HEALTH PLANS.**

14          (a) IN GENERAL.—Subject to subsection (b), sections  
15   1301 and 1302 shall apply to group health plans providing  
16   health coverage in the same manner as they apply to car-  
17   riers providing health insurance coverage.

18          (b) SUBSTITUTION OF REFERENCES.—For purposes  
19   of subsection (a), any reference in section 1301 or 1302  
20   to—

21               (1) a State or the Secretary of Health and  
22   Human Services is deemed a reference to the Sec-  
23   retary of Labor, and

1           (2) a carrier or health insurance coverage is  
2       deemed a reference to a group health plan and  
3       health coverage, respectively.

4   **SEC. 1304. ENFORCEMENT.**

5       (a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR  
6   EMPLOYERS AND GROUP HEALTH PLANS.—

7           (1) IN GENERAL.—For purposes of part 5 of  
8       subtitle B of title I of the Employee Retirement In-  
9       come Security Act of 1974, the provisions of this  
10      title insofar as they relate to group health plans or  
11      employers shall be deemed to be provisions of title  
12      I of such Act irrespective of exclusions under section  
13      4(b) of such Act.

14          (2) REGULATORY AUTHORITY.—With respect to  
15      the regulatory authority of the Secretary of Labor  
16      under this subtitle pursuant to paragraph (1), sec-  
17      tion 505 of the Employee Retirement Income Secu-  
18      rity Act of 1974 (29 U.S.C. 1135) shall apply.

19      (b) ENFORCEMENT BY EXCISE TAX FOR CAR-  
20   RIERS.—

21          (1) IN GENERAL.—Chapter 43 of the Internal  
22      Revenue Code of 1986 (relating to qualified pension  
23      plans, etc.) is amended by adding at the end thereof  
24      the following new section:

1 **“SEC. 4980C. FAILURE OF CARRIER TO COMPLY WITH**  
2 **HEALTH INSURANCE STANDARDS.**

3 “(a) IMPOSITION OF TAX.—

4 “(1) IN GENERAL.—There is hereby imposed a  
5 tax on the failure of a carrier to comply with the re-  
6 quirements applicable to the carrier under parts 1  
7 through 4 of subtitle A and subtitle B of title I of  
8 the Bipartisan Health Care Reform Act of 1994.

9 “(2) EXCEPTION.—Paragraph (1) shall not  
10 apply to a failure by a carrier in a State if the Sec-  
11 retary of Health and Human Services determines  
12 that the State has in effect a regulatory enforcement  
13 mechanism that provides adequate sanctions with re-  
14 spect to such a failure by such a carrier.

15 “(b) AMOUNT OF TAX.—

16 “(1) IN GENERAL.—Subject to paragraph (2),  
17 the amount of the tax imposed by subsection (a)  
18 shall be \$100 for each day during which such failure  
19 persists for each individual to which such failure re-  
20 lates. A rule similar to the rule of section  
21 4980B(b)(3) shall apply for purposes of this section.

22 “(2) LIMITATION.—The amount of the tax im-  
23 posed by subsection (a) for a carrier with respect to  
24 health insurance coverage shall not exceed 25 per-  
25 cent of the amounts received for such coverage dur-  
26 ing the period such failure persists.

1       “(c) LIABILITY FOR TAX.—The tax imposed by this  
2 section shall be paid by the carrier.

3       “(d) EXCEPTIONS.—

4               “(1) CORRECTIONS WITHIN 30 DAYS.—No tax  
5 shall be imposed by subsection (a) by reason of any  
6 failure if—

7                       “(A) such failure was due to reasonable  
8 cause and not to willful neglect, and

9                       “(B) such failure is corrected within the  
10 30-day period beginning on the earliest date the  
11 carrier knew, or exercising reasonable diligence  
12 would have known, that such failure existed.

13               “(2) WAIVER BY SECRETARY.—In the case of a  
14 failure which is due to reasonable cause and not to  
15 willful neglect, the Secretary may waive part or all  
16 of the tax imposed by subsection (a) to the extent  
17 that payment of such tax would be excessive relative  
18 to the failure involved.

19       “(e) DEFINITIONS.—For purposes of this section, the  
20 terms ‘health insurance coverage’ and ‘carrier’ have the  
21 respective meanings given such terms in section 1903 of  
22 the Bipartisan Health Care Reform Act of 1994.”

23               (2) CLERICAL AMENDMENT.—The table of sec-  
24 tions for chapter 43 of such Code is amended by  
25 adding at the end thereof the following new item:



“Sec. 4980C. Failure of carrier to comply with health insurance standards.”

1 **SEC. 1305. LIMITATION ON SELF INSURANCE FOR SMALL**  
2 **EMPLOYERS.**

3 A single employer plan (as defined in section  
4 3(40)(B) of the Employee Retirement Income Security  
5 Act of 1974) may not offer health coverage other than  
6 through a carrier unless the plan has at least 100 eligible  
7 employees.

8 **Subtitle E—Multiple Employer**  
9 **Health Benefits Protections and**  
10 **Related Provisions**

11 **PART 1—MULTIPLE EMPLOYER HEALTH**  
12 **BENEFITS PROTECTIONS**

13 **SEC. 1401. LIMITED EXEMPTION FROM CERTAIN RESTRIC-**  
14 **TIONS ON ERISA PREEMPTION OF STATE LAW**  
15 **FOR HEALTH PLANS MAINTAINED BY MUL-**  
16 **TIPLE EMPLOYERS SUBJECT TO CERTAIN**  
17 **FEDERAL STANDARDS.**

18 (a) IN GENERAL.—Subtitle B of title I of the Em-  
19 ployee Retirement Income Security Act of 1974 is amend-  
20 ed by adding at the end the following new part:

21 “PART 7—MULTIPLE EMPLOYER HEALTH PLANS  
22 “SEC. 701. DEFINITIONS.

23 “For purposes of this part—

1           “(1) INSURER.—The term ‘insurer’ means an  
2           insurance company, insurance service, or insurance  
3           organization, licensed to engage in the business of  
4           insurance by a State.

5           “(2) PARTICIPATING EMPLOYER.—The term  
6           ‘participating employer’ means, in connection with a  
7           multiple employer welfare arrangement, any em-  
8           ployer if any of its employees, or any of the depend-  
9           ents of its employees, are or were covered under  
10          such arrangement in connection with the employ-  
11          ment of the employees.

12          “(3) EXCESS/STOP LOSS COVERAGE.—The term  
13          ‘excess/stop loss coverage’ means, in connection with  
14          a multiple employer welfare arrangement, a contract  
15          under which an insurer provides for payment with  
16          respect to claims under the arrangement, relating to  
17          participants or beneficiaries individually or other-  
18          wise, in excess of an amount or amounts specified in  
19          such contract.

20          “(4) QUALIFIED ACTUARY.—The term ‘quali-  
21          fied actuary’ means an individual who is a member  
22          of the American Academy of Actuaries or meets  
23          such reasonable standards and qualifications as the  
24          Secretary may provide by regulation.

1           “(5) SPONSOR.—The term ‘sponsor’ means, in  
2           connection with a multiple employer welfare arrange-  
3           ment, the association or other entity which estab-  
4           lishes or maintains the arrangement.

5           “(6) STATE INSURANCE COMMISSIONER.—The  
6           term ‘State insurance commissioner’ means the in-  
7           surance commissioner (or similar official) of a State.

8           “(7) DOMICILE STATE.—The term ‘domicile  
9           State’ means, in connection with a multiple employer  
10          welfare arrangement, the State in which, according  
11          to the application for a certification under this part,  
12          most individuals to be covered under the arrange-  
13          ment are located, except that, in any case in which  
14          information contained in the latest annual report of  
15          the arrangement filed under this part indicates that  
16          most individuals covered under the arrangement are  
17          located in a different State, such term means such  
18          different State.

19          “(8) FULLY INSURED.—Coverage under a mul-  
20          tiple employer welfare arrangement is ‘fully insured’  
21          if one or more insurers, health maintenance organi-  
22          zations, similar organizations regulated under State  
23          law for solvency, or any combination thereof are lia-  
24          ble under one or more insurance policies or contracts  
25          for all benefits under the arrangement (irrespective

1 of any recourse they may have against other par-  
2 ties).

3 “(9) CERTIFIED MULTIPLE EMPLOYER HEALTH  
4 PLAN.—The term ‘certified multiple employer health  
5 plan’ means a multiple employer welfare arrange-  
6 ment treated as an employee welfare benefit plan by  
7 reason of certification under this part.

8 **“SEC. 702. CERTIFIED MULTIPLE EMPLOYER HEALTH**  
9 **PLANS RELIEVED OF CERTAIN RESTRIC-**  
10 **TIONS ON PREEMPTION OF STATE LAW AND**  
11 **TREATED AS EMPLOYEE WELFARE BENEFIT**  
12 **PLANS.**

13 “(a) IN GENERAL.—Subject to subsection (b), a mul-  
14 tiple employer welfare arrangement under which coverage  
15 is not fully insured and with respect to which there is in  
16 effect a certification granted by the Secretary under this  
17 part (or with respect to which there is pending a complete  
18 application for such a certification and the Secretary de-  
19 termines that provisional protection under this part is ap-  
20 propriate)—

21 “(1) shall be treated for purposes of subtitle A  
22 and the preceding parts of this subtitle as an em-  
23 ployee welfare benefit plan, irrespective of whether  
24 such arrangement is an employee welfare benefit  
25 plan, and

1           “(2) shall be exempt from section  
2       514(b)(6)(A)(ii).

3       “(b) BENEFITS MUST CONSIST OF MEDICAL  
4 CARE.—Subsection (a) shall apply to a multiple employer  
5 welfare arrangement only if the benefits provided there-  
6 under consist solely of medical care described in section  
7 607(1) (disregarding such incidental benefits as the  
8 Secretary shall specify by regulation).

9       **“SEC. 703. CERTIFICATION PROCEDURE.**

10       “(a) IN GENERAL.—The Secretary shall grant a cer-  
11 tification described in section 702(a) to a multiple em-  
12 ployer welfare arrangement if—

13           “(1) an application for such certification with  
14 respect to such arrangement, identified individually  
15 or by class, has been duly filed in complete form  
16 with the Secretary in accordance with this part,

17           “(2) such application demonstrates compliance  
18 with the requirements of section 704 with respect to  
19 such arrangement, and

20           “(3) the Secretary finds that such certification  
21 is—

22                   “(A) administratively feasible,

23                   “(B) not adverse to the interests of the in-  
24 dividuals covered under the arrangement, and

1           “(C) protective of the rights and benefits  
2           of the individuals covered under the arrange-  
3           ment.

4           “(b) NOTICE AND HEARING.—Before granting a cer-  
5           tification under this section, the Secretary shall publish  
6           notice in the Federal Register of the pendency of the cer-  
7           tification, shall require that adequate notice be given to  
8           interested persons, including the State insurance commis-  
9           sioner of each State in which covered individuals under  
10          the arrangement are, or are expected to be, located, and  
11          shall afford interested persons opportunity to present  
12          views. The Secretary may not grant a certification under  
13          this section unless the Secretary affords an opportunity  
14          for a hearing and makes a determination on the record  
15          with respect to the findings required under subsection  
16          (a)(3). The Secretary shall, to the maximum extent prac-  
17          ticable, make a final determination with respect to any ap-  
18          plication filed under this section in the case of a newly  
19          established arrangement within 90 days after the date  
20          which the Secretary determines is the date on which such  
21          application is filed in complete form.

22       **“SEC. 704. ELIGIBILITY REQUIREMENTS.**

23           “(a) APPLICATION FOR CERTIFICATION.—

24           “(1) IN GENERAL.—A certification may be  
25          granted by the Secretary under this part only on the

1 basis of an application filed with the Secretary in  
2 such form and manner as shall be prescribed in reg-  
3 ulations of the Secretary. Any such application shall  
4 be signed by the operating committee and the spon-  
5 sor of the arrangement.

6 “(2) FILING FEE.—The arrangement shall pay  
7 to the Secretary at the time of filing an application  
8 under this section a filing fee in the amount of  
9 \$5,000, which shall be available, to the extent pro-  
10 vided in appropriation Acts, to the Secretary for the  
11 sole purpose of administering the certification proce-  
12 dures under this part.

13 “(3) INFORMATION INCLUDED.—An application  
14 filed under this section shall include, in a manner  
15 and form prescribed in regulations of the Secretary,  
16 at least the following information:

17 “(A) IDENTIFYING INFORMATION.—The  
18 names and addresses of—

19 “(i) the sponsor, and

20 “(ii) the members of the operating  
21 committee of the arrangement.

22 “(B) STATES IN WHICH ARRANGEMENT IN-  
23 TENDS TO DO BUSINESS.—The States in which  
24 individuals covered under the arrangement are

1 to be located and the number of such individ-  
2 uals expected to be located in each such State.

3 “(C) BONDING REQUIREMENTS.—Evidence  
4 provided by the operating committee that the  
5 bonding requirements of section 412 will be met  
6 as of the date of the application.

7 “(D) PLAN DOCUMENTS.—A copy of the  
8 documents governing the arrangement (includ-  
9 ing any bylaws and trust agreements), the sum-  
10 mary plan description, and other material de-  
11 scribing the benefits and coverage that will be  
12 provided to individuals covered under the ar-  
13 rangement.

14 “(E) AGREEMENTS WITH SERVICE PROVID-  
15 ERS.—A copy of any agreements between the  
16 arrangement and contract administrators and  
17 other service providers.

18 “(F) FUNDING REPORT.—A report setting  
19 forth information determined as of a date with-  
20 in the 120-day period ending with the date of  
21 the application, including the following:

22 “(i) RESERVES.—A statement, cer-  
23 tified by the operating committee of the ar-  
24 rangement, and a statement of actuarial  
25 opinion, signed by a qualified actuary, that



1 all applicable requirements of section 707  
2 are or will be met in accordance with regu-  
3 lations which the Secretary shall prescribe.

4 “(ii) ADEQUACY OF CONTRIBUTION  
5 RATES.—A statement of actuarial opinion,  
6 signed by a qualified actuary, which sets  
7 forth a description of the extent to which  
8 contribution rates are adequate to provide  
9 for the payment of all obligations and the  
10 maintenance of required reserves under the  
11 arrangement for the 12-month period be-  
12 ginning with such date within such 120-  
13 day period, taking into account the ex-  
14 pected coverage and experience of the ar-  
15 rangement. If the contribution rates are  
16 not fully adequate, the statement of actu-  
17 arial opinion shall indicate the extent to  
18 which the rates are inadequate and the  
19 changes needed to ensure adequacy.

20 “(iii) CURRENT AND PROJECTED  
21 VALUE OF ASSETS AND LIABILITIES.—A  
22 statement of actuarial opinion signed by a  
23 qualified actuary, which sets forth the cur-  
24 rent value of the assets and liabilities accu-  
25 mulated under the arrangement and a pro-

1           jection of the assets, liabilities, income,  
2           and expenses of the arrangement for the  
3           12-month period referred to in clause (ii).  
4           The income statement shall identify sepa-  
5           rately the arrangement’s administrative ex-  
6           penses and claims.

7           “(iv) COSTS OF COVERAGE TO BE  
8           CHARGED AND OTHER EXPENSES.—A  
9           statement of the costs of coverage to be  
10          charged, including an itemization of  
11          amounts for administration, reserves, and  
12          other expenses associated with the oper-  
13          ation of the arrangement.

14          “(v) OTHER INFORMATION.—Any  
15          other information which may be prescribed  
16          in regulations of the Secretary as nec-  
17          essary to carry out the purposes of this  
18          part.

19          “(b) OTHER REQUIREMENTS.—A complete applica-  
20          tion for a certification under this part shall include infor-  
21          mation which the Secretary determines to be complete and  
22          accurate and sufficient to demonstrate that the following  
23          requirements are met with respect to the arrangement:

24               “(1) SPONSOR.—

1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (B), the sponsor is, and has been (to-  
3 gether with its immediate predecessor, if any)  
4 for a continuous period of not less than 3 years  
5 before the date of the application, organized  
6 and maintained in good faith, with a constitu-  
7 tion and bylaws specifically stating its purpose,  
8 as a trade association, an industry association,  
9 a professional association, or a chamber of com-  
10 merce (or similar business group), for substan-  
11 tial purposes other than that of obtaining or  
12 providing medical care described in section  
13 607(1), and the applicant demonstrates to the  
14 satisfaction of the Secretary that the sponsor is  
15 established as a permanent entity which re-  
16 ceives the active support of its members.

17           “(B) SPECIAL RULE FOR EMPLOYERS IN  
18 THE SAME TRADE OR BUSINESS.—In the case  
19 of an arrangement under which all participating  
20 employers are engaged in a common type of  
21 trade or business, the sponsor is the operating  
22 committee of the arrangement.

23           “(2) OPERATING COMMITTEE.—The arrange-  
24 ment is operated, pursuant to a trust agreement, by  
25 an operating committee which has complete fiscal

1 control over the arrangement and which is respon-  
2 sible for all operations of the arrangement, and the  
3 operating committee has in effect rules of operation  
4 and financial controls, based on a 3-year plan of op-  
5 eration, adequate to carry out the terms of the ar-  
6 rangement and to meet all requirements of this title  
7 applicable to the arrangement. The members of the  
8 committee are individuals selected from individuals  
9 who are the owners, officers, directors, or employees  
10 of the participating employers or who are partners  
11 in the participating employers and actively partici-  
12 pate in the business. No such member is an owner,  
13 officer, director, or employee of, or partner in, a con-  
14 tract administrator or other service provider to the  
15 arrangement, except that officers or employees of a  
16 sponsor which is a service provider (other than a  
17 contract administrator) to the arrangement may be  
18 members of the committee if they constitute not  
19 more than 25 percent of the membership of the com-  
20 mittee and they do not provide services to the ar-  
21 rangement other than on behalf of the sponsor. The  
22 committee has sole authority to approve applications  
23 for participation in the arrangement and to contract  
24 with a service provider to administer the day-to-day  
25 affairs of the arrangement.

1           “(3) CONTENTS OF GOVERNING INSTRU-  
2           MENTS.—The instruments governing the arrange-  
3           ment include a written instrument, meeting the re-  
4           quirements of an instrument required under section  
5           402(a)(1), which—

6                   “(A) provides that the committee serves as  
7                   the named fiduciary required for plans under  
8                   such section and serves in the capacity of a  
9                   plan administrator (referred to in section  
10                  3(16)(A)),

11                  “(B) provides that the sponsor is to serve  
12                  as plan sponsor (referred to in section  
13                  3(16)(B)),

14                  “(C) incorporates the requirements of sec-  
15                  tion 707, and

16                  “(D) provides that, effective upon the  
17                  granting of a certification under this part—

18                          “(i) all participating employers must  
19                          be members or affiliated members of the  
20                          sponsor, except that, in the case of a spon-  
21                          sor which is a professional association or  
22                          other individual-based association, if at  
23                          least one of the officers, directors, or em-  
24                          ployees of an employer, or at least one of  
25                          the individuals who are partners in an em-

1           ployer and who actively participates in the  
2           business, is a member or affiliated member  
3           of the sponsor, participating employers  
4           may also include such employer, and

5           “(ii) all individuals thereafter com-  
6           mencing coverage under the arrangement  
7           must be—

8                   “(I) active or retired owners, offi-  
9                   cers, directors, or employees of, or  
10                  partners in, participating employers,  
11                  or

12                  “(II) the beneficiaries of individ-  
13                  uals described in subclause (I).

14           “(4) CONTRIBUTION RATES.—The contribution  
15           rates referred to in subsection (a)(3)(F)(ii) are  
16           adequate.

17           “(5) OPTION OF FAMILY COVERAGE.—If the ar-  
18           rangement provides for coverage with respect to an  
19           employee, the arrangement shall make available the  
20           option of coverage of family members of the individ-  
21           ual (as defined in section 1901(2) of the Bipartisan  
22           Health Care Reform Act of 1994).

23           “(6) MISCELLANEOUS REQUIREMENTS.—(A)  
24           The requirements of the title I of the Bipartisan

1 Health Care Reform Act of 1994 (insofar as they  
2 apply to group health plans), including the following:

3 “(i) Section 1003(c) (relating to guaran-  
4 teed renewal).

5 “(ii) Section 1004 (relating to restricting  
6 preexisting condition exclusions).

7 “(iii) Section 1005 (relating to choice of  
8 coverage through open enrollment).

9 “(iv) Section 1011 (relating to standards  
10 for managed care arrangements).

11 “(v) Section 1012 (relating to utilization  
12 review).

13 “(vi) Section 1013 (relating to standards  
14 for essential community providers).

15 “(vii) Section 1021(d) (relating to use of  
16 fair rating practices).

17 “(viii) Section 1022 (relating to coordina-  
18 tion with premium assistance certificate pro-  
19 gram).

20 “(B) The requirements of section 1023 of the  
21 Bipartisan Health Care Reform Act of 1994 (relat-  
22 ing to establishment of risk adjustment mechanisms)  
23 insofar as such requirements apply to carriers but  
24 only with respect to covered individuals in the indi-  
25 vidual/small group market.

1           “(7) REGULATORY REQUIREMENTS.—Such  
2       other requirements as the Secretary may prescribe  
3       by regulation as necessary to carry out the purposes  
4       of this part.

5           “(c) TREATMENT OF PARTY SEEKING CERTIFI-  
6       CATION WHERE PARTY IS SUBJECT TO DISQUALIFICA-  
7       TION.—

8           “(1) IN GENERAL.—In the case of any applica-  
9       tion for a certification under this part with respect  
10      to a multiple employer welfare arrangement, if the  
11      Secretary determines that the sponsor of the ar-  
12      rangement or any other person associated with the  
13      arrangement is subject to disqualification under  
14      paragraph (2), the Secretary may deny the certifi-  
15      cation with respect to such arrangement.

16          “(2) DISQUALIFICATION.—A person is subject  
17      to disqualification under this paragraph if such  
18      person—

19              “(A) has intentionally made a material  
20          misstatement in the application for certifi-  
21          cation;

22              “(B) has obtained or attempted to obtain  
23          a certification under this part through mis-  
24          representation or fraud;



1           “(C) has misappropriated or converted to  
2           such person’s own use, or improperly withheld,  
3           money held under a plan or any multiple  
4           employer welfare arrangement;

5           “(D) is prohibited (or would be prohibited  
6           if the arrangement were a plan) from serving in  
7           any capacity in connection with the arrange-  
8           ment under section 411;

9           “(E) has failed to appear without reason-  
10          able cause or excuse in response to a subpoena,  
11          examination, warrant, or any other order law-  
12          fully issued by the Secretary compelling such  
13          response;

14          “(F) has previously been subject to a de-  
15          termination under this part resulting in the de-  
16          nial, suspension, or revocation of a certification  
17          under this part on similar grounds; or

18          “(G) has otherwise violated any provision  
19          of this title with respect to a matter which the  
20          Secretary determines of sufficient consequence  
21          to merit disqualification for purposes of this  
22          part.

23          “(d) FRANCHISE NETWORKS.—In the case of a mul-  
24          tiple employer welfare arrangement established and main-  
25          tained by a franchisor for a franchise network consisting

1 of its franchisees, such franchisor shall be treated as the  
2 sponsor referred to in the preceding provisions of this sec-  
3 tion, such network shall be treated as an association re-  
4 ferred to in such provisions, and each franchisee shall be  
5 treated as a member (of the association and the sponsor)  
6 referred to in such provisions, if all participating employ-  
7 ers are such franchisees and the requirements of sub-  
8 section (b)(1) with respect to a sponsor are met with  
9 respect to the network.

10 “(e) CERTAIN COLLECTIVELY BARGAINED ARRANGE-  
11 MENTS.—In applying the preceding provisions of this sec-  
12 tion in the case of a multiple employer welfare arrange-  
13 ment which would be described in section 3(40)(A)(i) but  
14 for the failure to meet any requirement of section  
15 3(40)(C)—

16 “(1) paragraphs (1) and (2) of subsection (b)  
17 and subparagraphs (A), (B), and (D) of paragraph  
18 (3) of subsection (b) shall be disregarded, and

19 “(2) the joint board of trustees shall be consid-  
20 ered the operating committee of the arrangement.

21 “(f) CERTAIN ARRANGEMENTS NOT MEETING SIN-  
22 GLE EMPLOYER REQUIREMENT.—

23 “(1) IN GENERAL.—In any case in which the  
24 majority of the employees covered under a multiple  
25 employer welfare arrangement are employees of a

1 single employer (within the meaning of clauses (i)  
2 and (ii) of section 3(40)(B)), if all other employees  
3 covered under the arrangement are employed by em-  
4 ployers who are related to such single employer, sub-  
5 section (b)(3)(D) shall be disregarded.

6 “(2) RELATED EMPLOYERS.—For purposes of  
7 paragraph (1), employers are ‘related’ if there is  
8 among all such employers a common ownership in-  
9 terest or a substantial commonality of business oper-  
10 ations based on common suppliers or customers.

11 **“SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO**  
12 **CERTIFIED MULTIPLE EMPLOYER HEALTH**  
13 **PLANS.**

14 “(a) NOTICE OF MATERIAL CHANGES.—In the case  
15 of any certified multiple employer health plan, descriptions  
16 of material changes in any information which was required  
17 to be submitted with the application for the certification  
18 granted under this part shall be filed in such form and  
19 manner as shall be prescribed in regulations of the Sec-  
20 retary. The Secretary may require by regulation prior no-  
21 tice of material changes with respect to specified matters  
22 which might serve as the basis for suspension or revoca-  
23 tion of the certification.

24 “(b) REPORTING REQUIREMENTS.—Under regula-  
25 tions of the Secretary, the requirements of sections 102,

1 103, and 104 shall apply with respect to any multiple em-  
2 ployer welfare arrangement which is or has been a cer-  
3 tified multiple employer health plan in the same manner  
4 and to the same extent as such requirements apply to em-  
5 ployee welfare benefit plans, irrespective of whether such  
6 certification continues in effect. The annual report re-  
7 quired under section 103 for any plan year in the case  
8 of any such multiple employer welfare arrangement shall  
9 also include information described in section 704(a)(3)(F)  
10 with respect to the plan year and, notwithstanding section  
11 104(a)(1)(A), shall be filed not later than 90 days after  
12 the close of the plan year.

13 “(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The  
14 operating committee of each multiple employer welfare ar-  
15 rangement which is or has been a certified multiple em-  
16 ployer health plan shall engage, on behalf of all covered  
17 individuals, a qualified actuary who shall be responsible  
18 for the preparation of the materials comprising informa-  
19 tion necessary to be submitted by a qualified actuary  
20 under this part. The qualified actuary shall utilize such  
21 assumptions and techniques as are necessary to enable  
22 such actuary to form an opinion as to whether the con-  
23 tents of the matters reported under this part—

1           “(1) are in the aggregate reasonably related to  
2           the experience of the arrangement and to reasonable  
3           expectations, and

4           “(2) represent such actuary’s best estimate of  
5           anticipated experience under the arrangement.

6   The opinion by the qualified actuary shall be made with  
7   respect to, and shall be made a part of, the annual report.

8           “(d) FILING NOTICE OF CERTIFICATION WITH  
9   STATES.—A certification granted to a multiple employer  
10   welfare arrangement under this part shall not be effective  
11   unless written notice of such certification is filed with the  
12   State insurance commissioner of each State in which at  
13   least 5 percent of the individuals covered under the ar-  
14   rangement are located. For purposes of this subsection,  
15   an individual shall be considered to be located in the State  
16   in which a known address of such individual is located or  
17   in which such individual is employed. The Secretary may  
18   by regulation provide in specified cases for the application  
19   of the preceding sentence with lesser percentages in lieu  
20   of such 5 percent amount.

21   **“SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY**  
22                           **ARRANGEMENTS PROVIDING MEDICAL CARE.**

23           “(a) IN GENERAL.—A multiple employer welfare ar-  
24   rangement providing benefits consisting of medical care

1 described in section 607(1) shall issue to each participat-  
2 ing employer—

3 “(1) a document equivalent to the summary  
4 plan description required of plans under part 1,

5 “(2) information describing the contribution  
6 rates applicable to participating employers, and

7 “(3) a statement indicating—

8 “(A) that the arrangement is not a li-  
9 censed insurer under the laws of any State,

10 “(B) whether coverage under the arrange-  
11 ment is fully insured, and

12 “(C) if coverage under the arrangement if  
13 not fully insured, (i) whether the arrangement  
14 is (or has ceased to be) a certified multiple em-  
15 ployer health plan, and (ii) if such an arrange-  
16 ment is a certified multiple employer health  
17 plan, that such arrangement is treated as an  
18 employee welfare benefit plan under this title.

19 “(b) TIME FOR DISCLOSURE.—Such information  
20 shall be issued to employers within such reasonable period  
21 of time before becoming participating employers as may  
22 be prescribed in regulations of the Secretary.

23 **“SEC. 707. MAINTENANCE OF RESERVES.**

24 “(a) IN GENERAL.—Each multiple employer welfare  
25 arrangement which is or has been a certified multiple em-

1   ployer health plan and under which coverage is not fully  
2   insured shall establish and maintain such excess/stop loss  
3   coverage as the Secretary considers appropriate and shall  
4   establish and maintain reserves, consisting of—

5           “(1) a reserve for unearned contributions,

6           “(2) a reserve for payment of claims reported  
7       and not yet paid and claims incurred but not yet re-  
8       ported, and for expected administrative costs with  
9       respect to such claims, and

10          “(3) a reserve, in an amount recommended by  
11       the qualified actuary, for any other obligations of  
12       the arrangement.

13       “(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—  
14   The total of the reserves described in subsection (a)(2)  
15   shall not be less than an amount equal to 25 percent of  
16   expected incurred claims and expenses for the plan year.

17       “(c) REQUIRED MARGIN.—In determining the  
18   amounts of reserves required under this section in connec-  
19   tion with any multiple employer welfare arrangement, the  
20   qualified actuary shall include a margin for error and  
21   other fluctuations taking into account the specific  
22   circumstances of such arrangement.

23       “(d) ADDITIONAL REQUIREMENTS.—The Secretary  
24   may provide such additional requirements relating to re-  
25   serves and excess/stop loss coverage as the Secretary con-

1   siders appropriate. Such requirements may be provided,  
2   by regulation or otherwise, with respect to any arrange-  
3   ment or any class of arrangements.

4       “(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COV-  
5   ERAGE.—The Secretary may provide for adjustments to  
6   the levels of reserves otherwise required under subsections  
7   (a) and (b) with respect to any arrangement or class of  
8   arrangements to take into account excess/stop loss cov-  
9   erage provided with respect to such arrangement or ar-  
10  rangements.

11       “(f) ALTERNATIVE MEANS OF COMPLIANCE.—The  
12   Secretary may permit an arrangement to substitute, for  
13   all or part of the reserves required under subsection (a),  
14   such security, guarantee, or other financial arrangement  
15   as the Secretary determines to be adequate to enable the  
16   arrangement to fully meet all its financial obligations on  
17   a timely basis.

18   **“SEC. 708. CORRECTIVE ACTIONS.**

19       “(a) ACTIONS TO AVOID DEPLETION OF RE-  
20   SERVES.—A multiple employer welfare arrangement with  
21   respect to which there is or has been in effect a certifi-  
22   cation granted under this part shall continue to meet the  
23   requirements of section 707, irrespective of whether such  
24   certification continues in effect. The operating committee  
25   of such arrangement shall determine semiannually wheth-



1 er the requirements of section 707 are met. In any case  
2 in which the committee determines that there is reason  
3 to believe that there is or will be a failure to meet such  
4 requirements, or the Secretary makes such a determina-  
5 tion and so notifies the committee, the committee shall  
6 immediately notify the qualified actuary engaged by the  
7 arrangement, and such actuary shall, not later than the  
8 end of the next following month, make such recommenda-  
9 tions to the committee for corrective action as the actuary  
10 determines necessary to ensure compliance with section  
11 707. Not later than 10 days after receiving from the actu-  
12 ary recommendations for corrective actions, the committee  
13 shall notify the Secretary (in such form and manner as  
14 the Secretary may prescribe by regulation) of such rec-  
15 ommendations of the actuary for corrective action, to-  
16 gether with a description of the actions (if any) that the  
17 committee has taken or plans to take in response to such  
18 recommendations. The committee shall thereafter report  
19 to the Secretary, in such form and frequency as the Sec-  
20 retary may specify to the committee, regarding corrective  
21 action taken by the committee until the requirements of  
22 section 707 are met.

23 “(b) TERMINATION.—

24 “(1) NOTICE OF TERMINATION.—In any case in  
25 which the operating committee of a multiple em-

1        employer welfare arrangement which is or has been a  
2        certified multiple employer health plan determines  
3        that there is reason to believe that the arrangement  
4        will terminate, the committee shall so inform the  
5        Secretary, shall develop a plan for winding up the  
6        affairs of the arrangement in connection with such  
7        termination in a manner which will result in timely  
8        payment of all benefits for which the arrangement is  
9        obligated, and shall submit such plan in writing to  
10       the Secretary. Actions required under this paragraph  
11       shall be taken in such form and manner as may be  
12       prescribed in regulations of the Secretary.

13                “(2) ACTIONS REQUIRED IN CONNECTION WITH  
14       TERMINATION.—In any case in which—

15                “(A) the Secretary has been notified under  
16       subsection (a) of a failure of a multiple em-  
17       ployer welfare arrangement which is or has  
18       been a certified multiple employer health plan  
19       to meet the requirements of section 707 and  
20       has not been notified by the operating commit-  
21       tee of the arrangement that corrective action  
22       has restored compliance with such require-  
23       ments, and

24                “(B) the Secretary determines that the  
25       continuing failure to meet the requirements of

1           section 707 can be reasonably expected to result  
2           in a continuing failure to pay benefits for which  
3           the arrangement is obligated,  
4           the operating committee of the arrangement shall, at  
5           the direction of the Secretary, terminate the ar-  
6           rangement and, in the course of the termination,  
7           take such actions as the Secretary may require as  
8           necessary to ensure that the affairs of the arrange-  
9           ment will be, to the maximum extent possible, wound  
10          up in a manner which will result in timely payment  
11          of all benefits for which the arrangement is  
12          obligated.

13   **“SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF**  
14                   **CERTIFICATION.**

15          “(a) EXPIRATION AND RENEWAL OF CERTIFI-  
16   CATION.—A certification granted to a multiple employer  
17   welfare arrangement under this part shall expire 3 years  
18   after the date on which the certification is granted. A cer-  
19   tification which has expired may be renewed by means of  
20   application for a certification in accordance with section  
21   704.

22          “(b) SUSPENSION OR REVOCATION OF CERTIFI-  
23   CATION BY SECRETARY.—The Secretary may suspend or  
24   revoke a certification granted to a multiple employer wel-  
25   fare arrangement under this part—

1           “(1) for any cause that may serve as the basis  
2           for the denial of an initial application for such a cer-  
3           tification under section 704, or

4           “(2) if the Secretary finds that—

5                   “(A) the arrangement, or the sponsor  
6                   thereof, in the transaction of business while  
7                   under the certification, has used fraudulent, co-  
8                   ercive, or dishonest practices, or has dem-  
9                   onstrated incompetence, untrustworthiness, or  
10                  financial irresponsibility,

11                   “(B) the arrangement, or the sponsor  
12                   thereof, is using such methods or practices in  
13                   the conduct of its operations, so as to render its  
14                   further transaction of operations hazardous or  
15                   injurious to participating employers, or covered  
16                  individuals,

17                   “(C) the arrangement, or the sponsor  
18                   thereof, has refused to be examined in accord-  
19                   ance with this part or to produce its accounts,  
20                   records, and files for examination in accordance  
21                  with this part, or

22                   “(D) any of the officers of the arrange-  
23                   ment, or the sponsor thereof, has refused to  
24                   give information with respect to the affairs of  
25                  the arrangement or the sponsor or to perform

1           any other legal obligation relating to such an  
2           examination when required by the Secretary in  
3           accordance with this part.

4 Any such suspension or revocation under this subsection  
5 shall be effective only upon a final decision of the Sec-  
6 retary made after notice and opportunity for a hearing  
7 is provided in accordance with section 710.

8       “(c) SUSPENSION OR REVOCATION OF CERTIFI-  
9 CATION UNDER COURT PROCEEDINGS.—A certification  
10 granted to a multiple employer welfare arrangement under  
11 this part may be suspended or revoked by a court of com-  
12 petent jurisdiction in an action by the Secretary brought  
13 under paragraph (2), (5), or (6) of section 502(a), except  
14 that the suspension or revocation under this subsection  
15 shall be effective only upon notification of the Secretary  
16 of such suspension or revocation.

17       “(d) NOTIFICATION OF PARTICIPATING EMPLOY-  
18 ERS.—All participating employers in a multiple employer  
19 welfare arrangement shall be notified of the expiration,  
20 suspension, or revocation of a certification granted to such  
21 arrangement under this part, by such persons and in such  
22 form and manner as shall be prescribed in regulations of  
23 the Secretary, not later than 20 days after such expiration  
24 or after receipt of notice of a final decision requiring such  
25 suspension or revocation.

1       “(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS,  
2 AND REVOCATIONS.—The Secretary shall publish all expi-  
3 rations of, and all final decisions to suspend or revoke,  
4 certifications granted under this part.

5       **“SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.**

6       “(a) IN GENERAL.—Any decision by the Secretary  
7 which involves the denial of an application by a multiple  
8 employer welfare arrangement for a certification under  
9 this part or the suspension or revocation of such a certifi-  
10 cation shall contain a statement of the specific reason or  
11 reasons supporting the Secretary’s action, including ref-  
12 erence to the specific terms of the certification and the  
13 statutory provision or provisions relevant to the deter-  
14 mination.

15       “(b) DENIALS OF APPLICATIONS.—In the case of the  
16 denial of an application for a certification under this part,  
17 the Secretary shall send a copy of the decision to the appli-  
18 cant by certified or registered mail at the address specified  
19 in the records of the Secretary. Such decision shall con-  
20 stitute the final decision of the Secretary unless the ar-  
21 rangement, or any party that would be prejudiced by the  
22 decision, files a written appeal of the denial within 30 days  
23 after the mailing of such decision. The Secretary may af-  
24 firm, modify, or reverse the initial decision. The decision  
25 on appeal shall become final upon the mailing of a copy

1 by certified or registered mail to the arrangement or party  
2 that filed the appeal.

3 “(c) SUSPENSIONS OR REVOCATIONS OF CERTIFI-  
4 CATION.—In the case of the suspension or revocation of  
5 a certification granted under this part, the Secretary shall  
6 send a copy of the decision to the arrangement by certified  
7 or registered mail at its address, as specified in the  
8 records of the Secretary. Upon the request of the arrange-  
9 ment, or any party that would be prejudiced by the sus-  
10 pension or revocation, filed within 15 days of the mailing  
11 of the Secretary’s decision, the Secretary shall schedule  
12 a hearing on such decision by written notice, sent by cer-  
13 tified or registered mail to the arrangement or party  
14 requesting such hearing. Such notice shall set forth—

15 “(1) a specific date and time for the hearing,  
16 which shall be within the 10-day period commencing  
17 20 days after the date of the mailing of the notice,  
18 and

19 “(2) a specific place for the hearing, which shall  
20 be in the District of Columbia or in the State and  
21 county thereof (or parish or other similar political  
22 subdivision thereof) in which is located the arrange-  
23 ment’s principal place of business.

1 The decision as affirmed or modified in such hearing shall  
2 constitute the final decision of the Secretary, unless such  
3 decision is reversed in such hearing.

4 **“SEC. 711. SMALL EMPLOYER POOLING ARRANGEMENTS.**

5       “(a) REQUIREMENTS FOR SEPAs APPLICABLE  
6 WHERE SIGNIFICANT NUMBER OF SMALL EMPLOYERS  
7 PARTICIPATE.—In any case in which coverage is provided  
8 for the current plan year under a multiple employer health  
9 plan and more than 10 percent of the participating em-  
10 ployers in the arrangement are small employers (as de-  
11 fined in section 1902 of the Bipartisan Health Care Re-  
12 form Act of 1994), the entity sponsoring such arrange-  
13 ment shall ensure that such arrangement is maintained  
14 for such year in the form of a small employer pooling ar-  
15 rangement.

16       “(b) REQUIREMENTS FOR SMALL EMPLOYER POOL-  
17 ING ARRANGEMENTS.—For purposes of this part, an ar-  
18 rangement is maintained in the form of a small employer  
19 pooling arrangement for any applicable fiscal year, if—

20               “(1) the benefits under the arrangement consist  
21 solely of medical care described in section 607(1)  
22 (disregarding such incidental benefits as the Sec-  
23 retary of Labor shall specify by regulations),

24               “(2) the general requirements of subsection (c)  
25 are met with respect to the arrangement, and



1           “(3) the arrangement constitutes a certified  
2           multiple employer health plan under this part and  
3           the requirements of subsection (c) are met with re-  
4           spect to the arrangement.

5           “(c) REQUIREMENTS FOR ARRANGEMENTS PROVID-  
6           ING SELF-INSURED COVERAGE.—

7           “(1) IN GENERAL.—The requirements of this  
8           subsection with respect to a small employer purchas-  
9           ing arrangement are as follows:

10           “(A) The arrangement meets the guaran-  
11           teed issue requirements specified in paragraph  
12           (2).

13           “(B) The arrangement participates in any  
14           risk adjustment mechanisms established under  
15           section 1023 of the Bipartisan Health Care Re-  
16           form Act of 1994.

17           “(C) Under the arrangement, with respect  
18           to all participating employers as of the begin-  
19           ning of each plan year, the total number of eli-  
20           gible employees is not less than 100.

21           “(2) REQUIRED SCOPE OF ELIGIBILITY FOR  
22           PARTICIPATING EMPLOYERS.—

23           “(A) IN GENERAL.—Under the terms of  
24           the written instruments governing the arrange-  
25           ment, all restrictions on the eligibility of em-

1        ployers to be participating employers in the ar-  
2        rangement are specifically set forth and consist  
3        solely of criteria described in subparagraph (B),  
4        and all employers with respect to whom such  
5        criteria are met may be participating employers.  
6        No such restrictions under the arrangement  
7        shall be considered enforceable unless they are  
8        so specified.

9            “(B) CRITERIA FOR RESTRICTIONS ON  
10        PARTICIPATING EMPLOYERS.—The terms of the  
11        arrangement shall define restrictions on eligi-  
12        bility of employers to be participating employers  
13        only by reference to one or more of the follow-  
14        ing criteria:

15            “(i) Participating employers are re-  
16        stricted to those located in one or more  
17        specified geographic locations.

18            “(ii) Participating employers are re-  
19        stricted to those who are (or whose owners,  
20        officers, or employees are) members of one  
21        or more trade associations, industry asso-  
22        ciations, professional associations, or  
23        chambers of commerce (or similar business  
24        groups).

1           “(iii) Participating employers are re-  
2           stricted to those who are otherwise related  
3           by specified supply contracts, franchise ar-  
4           rangements, or common ownership inter-  
5           ests.

6           “(iv) Participating employers are re-  
7           stricted to employers whose employees are  
8           covered under one or more specified collec-  
9           tive bargaining agreements.

10       “(d) REFERENCE TO LIMITATION ON SELF-INSUR-  
11       ANCE BY SMALL EMPLOYERS.—For restriction on self-in-  
12       surance by small employers, see section 1305 of the Bipar-  
13       tisan Health Care Reform Act of 1994.”.

14       (b) CONFORMING AMENDMENT TO DEFINITION OF  
15       PLAN SPONSOR.—Section 3(16)(B) of such Act (29  
16       U.S.C. 1002(16)(B)) is amended by adding at the end the  
17       following new sentence: “Such term also includes the spon-  
18       sor (as defined in section 701(5)) of a multiple employer  
19       welfare arrangement which is or has been a certified mul-  
20       tiple employer health plan (as defined in section 701(9)).”.

21       (c) ALTERNATIVE MEANS OF DISTRIBUTION OF  
22       SUMMARY PLAN DESCRIPTIONS.—Section 110 of such  
23       Act (29 U.S.C. 1030) is amended by adding at the end  
24       the following new subsection:

1       “(c) The Secretary shall prescribe, as an alternative  
 2 method for distributing summary plan descriptions in  
 3 order to meet the requirements of section 104(b)(1) in the  
 4 case of multiple employer welfare arrangements providing  
 5 benefits consisting of medical care described in section  
 6 607(1), a means of distribution of such descriptions by  
 7 participating employers.”.

8       (d) CLERICAL AMENDMENT.—The table of contents  
 9 in section 1 of the Employee Retirement Income Security  
 10 Act of 1974 is amended by inserting after the item relat-  
 11 ing to section 608 the following new items:

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Certified multiple employer health plans relieved of certain restric-  
 tions on preemption of State law and treated as employee wel-  
 fare benefit plans.

“Sec. 703. Certification procedure.

“Sec. 704. Eligibility requirements.

“Sec. 705. Additional requirements applicable to certified multiple employer  
 health plans.

“Sec. 706. Disclosure to participating employers by arrangements providing  
 medical care.

“Sec. 707. Maintenance of reserves.

“Sec. 708. Corrective actions.

“Sec. 709. Expiration, suspension, or revocation of certification.

“Sec. 710. Review of actions of the Secretary.

“Sec. 711. Small employer pooling arrangement.”.

12 **SEC. 1402. CLARIFICATION OF SCOPE OF PREEMPTION**

13 **RULES.**

14       (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the  
 15 Employee Retirement Income Security Act of 1974 (29  
 16 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting “, but  
 17 only, in the case of an arrangement which provides medi-

1 cal care described in section 607(1) and with respect to  
2 which a certification under part 7 is not in effect,” before  
3 “to the extent not inconsistent with the preceding sections  
4 of this title”.

5 (b) CROSS-REFERENCE.—Section 514(b)(6) of such  
6 Act (29 U.S.C. 1144(b)(6)) is amended by adding at the  
7 end the following new subparagraph:

8 “(E) For additional rules relating to exemption from  
9 subparagraph (A)(ii) of multiple employer welfare ar-  
10 rangements providing medical care, see part 7.”.

11 **SEC. 1403. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
12 **PLOYER ARRANGEMENTS.**

13 Section 3(40)(B) of the Employee Retirement Income  
14 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is  
15 amended—

16 (1) in clause (i), by inserting “for any plan year  
17 of any such plan, or any fiscal year of any such  
18 other arrangement,” after “single employer”, and by  
19 inserting “during such year or at any time during  
20 the preceding 1-year period” after “common con-  
21 trol”;

22 (2) in clause (iii), by striking “common control  
23 shall not be based on an interest of less than 25 per-  
24 cent” and inserting “an interest of greater than 25  
25 percent may not be required as the minimum inter-

1 est necessary for common control”, and by striking  
2 “and” at the end;

3 (3) by redesignating clauses (iv) and (v) as  
4 clauses (v) and (vi); and

5 (4) by inserting after clause (iii) the following  
6 new clause:

7 “(iv) in determining, after the application of  
8 clause (i), whether benefits are provided to employ-  
9 ees of two or more employers, the arrangement shall  
10 be treated as having only 1 participating employer  
11 if, at the time the determination under clause (i) is  
12 made, the number of individuals who are employees  
13 and former employees of any one participating em-  
14 ployer and who are covered under the arrangement  
15 is greater than 95 percent of the aggregate number  
16 of all individuals who are employees or former em-  
17 ployees of participating employers and who are  
18 covered under the arrangement,”.

19 **SEC. 1404. CLARIFICATION OF TREATMENT OF CERTAIN**  
20 **COLLECTIVELY BARGAINED ARRANGE-**  
21 **MENTS.**

22 (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-  
23 ployee Retirement Income Security Act of 1974 (29  
24 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

1 “(i) under or pursuant to one or more collective  
2 bargaining agreements,”.

3 (b) LIMITATIONS.—Section 3(40) of such Act (29  
4 U.S.C. 1002(40)) is amended by adding at the end the  
5 following new subparagraphs:

6 “(C) Clause (i) of subparagraph (A) shall apply only  
7 if—

8 “(i) the plan or other arrangement, and the em-  
9 ployee organization or any other entity sponsoring  
10 the plan or other arrangement, do not—

11 “(I) utilize the services of any licensed in-  
12 surance agent or broker for soliciting or enroll-  
13 ing employers or individuals as participating  
14 employers or covered individuals under the plan  
15 or other arrangement, or

16 “(II) pay a commission or any other type  
17 of compensation to a person that is related ei-  
18 ther to the volume or number of employers or  
19 individuals solicited or enrolled as participating  
20 employers or covered individuals under the plan  
21 or other arrangement, or to the dollar amount  
22 or size of the contributions made by participat-  
23 ing employers or covered individuals to the plan  
24 or other arrangement,

1           “(ii) not less than 85 percent of the covered in-  
2           dividuals under the plan or other arrangement are  
3           individuals who—

4                   “(I) are employed within a bargaining unit  
5                   covered by at least one of the collective bargain-  
6                   ing agreements with a participating employer  
7                   (or are covered on the basis of an individual’s  
8                   employment in such a bargaining unit), or

9                   “(II) are present or former employees of  
10                  the sponsoring employee organization, of an  
11                  employer who is or was a party to at least one  
12                  of the collective bargaining agreements, or of  
13                  the plan or other arrangement or a related plan  
14                  or arrangement (or are covered on the basis of  
15                  such present or former employment),

16           “(iii) the plan or other arrangement does not  
17           provide benefits to individuals (other than individ-  
18           uals described in clause (ii)(II)) who work outside  
19           the standard metropolitan statistical area in which  
20           the sponsoring employee organization represents em-  
21           ployees (or to individuals (other than individuals de-  
22           scribed in clause (ii)(II)) on the basis of such work  
23           by others), except that in the case of a sponsoring  
24           employee organization that represents employees  
25           who work outside of any standard metropolitan sta-



1        tistical area, this clause shall be applied by reference  
2        to the State in which the sponsoring organization  
3        represents employees, and

4            “(iv) the employee organization or other entity  
5        sponsoring the plan or other arrangement certifies  
6        to the Secretary each year, in a form and manner  
7        which shall be prescribed in regulations of the Sec-  
8        retary—

9            “(I) that the plan or other arrangement  
10        meets the requirements of clauses (i), (ii), and  
11        (iii), and

12            “(II) if, for any year, 10 percent or more  
13        of the covered individuals under the plan are in-  
14        dividuals not described in subclause (I) or (II)  
15        of clause (ii), the total number of covered indi-  
16        viduals and the total number of covered individ-  
17        uals not so described.

18        “(D)(i) Clause (i) of subparagraph (A) shall not  
19        apply to a plan or other arrangement that is established  
20        or maintained pursuant to one or more collective bargain-  
21        ing agreements which the National Labor Relations Board  
22        determines to have been negotiated or otherwise agreed  
23        to in a manner or through conduct which violates section  
24        8(a)(2) of the National Labor Relations Act (29 U.S.C.  
25        158(a)(2)).

1       “(ii)(I) Whenever a State insurance commissioner  
2 has reason to believe that this subparagraph is applicable  
3 to part or all of a plan or other arrangement, the State  
4 insurance commissioner may file a petition with the Na-  
5 tional Labor Relations Board for a determination under  
6 clause (i), along with sworn written testimony supporting  
7 the petition.

8       “(II) The Board shall give any such petition priority  
9 over all other petitions and cases, other than other peti-  
10 tions under subclause (I) or cases given priority under sec-  
11 tion 10 of the National Labor Relations Act (29 U.S.C.  
12 160).

13       “(III) The Board shall determine, upon the petition  
14 and any response, whether, on the facts before it, the plan  
15 or other arrangement was negotiated, created, or other-  
16 wise agreed to in a manner or through conduct which vio-  
17 lates section 8(a)(2) of the National Labor Relations Act  
18 (29 U.S.C. 158(a)(2)). Such determination shall con-  
19 stitute a final determination for purposes of this subpara-  
20 graph and shall be binding in all Federal or State actions  
21 with respect to the status of the plan or other arrangement  
22 under this subparagraph.

23       “(IV) A person aggrieved by the determination of the  
24 Board under subclause (III) may obtain review of the de-  
25 termination in any United States court of appeals in the

1 circuit in which the collective bargaining at issue occurred.  
2 Commencement of proceedings under this subclause shall  
3 not, unless specifically ordered by the court, operate as  
4 a stay of any State administrative or judicial action or  
5 proceeding related to the status of the plan or other ar-  
6 rangement, except that in no case may the court stay, be-  
7 fore the completion of the review, an order which prohibits  
8 the enrollment of new individuals into coverage under a  
9 plan or arrangement.”.

10 **SEC. 1405. EMPLOYEE LEASING HEALTH CARE ARRANGE-**  
11 **MENTS.**

12 (a) EMPLOYEE LEASING HEALTH CARE ARRANGE-  
13 MENT DEFINED.—Section 3 of the Employee Retirement  
14 Income Security Act of 1974 (29 U.S.C. 1002) is amended  
15 by adding at the end the following new paragraph:

16 “(43)(A) Subject to subparagraph (B), the term ‘em-  
17 ployee leasing health care arrangement’ means any labor  
18 leasing arrangement, staff leasing arrangement, extended  
19 employee staffing or supply arrangement, or other ar-  
20 rangement under which—

21 “(i) one business or other entity (hereinafter in  
22 this paragraph referred to as the ‘lessee’), under a  
23 lease or other arrangement entered into with any  
24 other business or other entity (hereinafter in this  
25 paragraph referred to as the ‘lessor’), receives from

1 the lessor the services of individuals to be performed  
2 under such lease or other arrangement, and

3 “(ii) benefits consisting of medical care de-  
4 scribed in section 607(1) are provided to such indi-  
5 viduals or such individuals and their dependents as  
6 participants and beneficiaries.

7 “(B) Such term does not include an arrangement de-  
8 scribed in subparagraph (A) if, under such arrangement,  
9 the lessor retains, both legally and in fact, a complete  
10 right of direction and control within the scope of employ-  
11 ment over the individuals whose services are supplied  
12 under such lease or other arrangement, and such individ-  
13 uals perform a specified function for the lessee which is  
14 separate and divisible from the primary business or oper-  
15 ations of the lessee.”.

16 (b) TREATMENT OF EMPLOYEE LEASING HEALTH  
17 CARE ARRANGEMENTS AS MULTIPLE EMPLOYER WEL-  
18 FARE ARRANGEMENTS.—Section 3(40) of such Act (29  
19 U.S.C. 1002(40)) (as amended by section 1404(b)) is fur-  
20 ther amended by adding at the end the following new sub-  
21 paragraph:

22 “(E) The term ‘multiple employer welfare arrange-  
23 ment’ includes any employee leasing health care arrange-  
24 ment.”.

1 (c) SPECIAL RULES FOR EMPLOYEE LEASING  
2 HEALTH CARE ARRANGEMENTS.—

3 (1) IN GENERAL.—Part 7 of subtitle B of title  
4 I of such Act (as added by section 1401(a)) is  
5 amended by adding at the end the following new sec-  
6 tion:

7 **“SEC. 712. SPECIAL RULES FOR EMPLOYEE LEASING**  
8 **HEALTH CARE ARRANGEMENTS.**

9 “(a) IN GENERAL.—The requirements of paragraphs  
10 (1), (2), and (3) of section 704(b) shall be treated as satis-  
11 fied in the case of a multiple employer welfare arrange-  
12 ment that is an employee leasing health care arrangement  
13 if the application for certification includes information  
14 which the Secretary determines to be complete and accu-  
15 rate and sufficient to demonstrate that the following  
16 requirements are met with respect to the arrangement:

17 “(1) 3-YEAR TENURE.—The lessor has been in  
18 operation for not less than 3 years.

19 “(2) SOLICITATION RESTRICTIONS.—Employee  
20 leasing services provided under the arrangement are  
21 not solicited, advertised, or marketed through li-  
22 censed insurance agents or brokers acting in such  
23 capacity.

24 “(3) CREATION OF EMPLOYMENT RELATION-  
25 SHIP.—

1           “(A) DISCLOSURE STATEMENT.—Written  
2           notice is provided to each applicant for employ-  
3           ment subject to coverage under the arrange-  
4           ment, at the time of application for employment  
5           and before commencing coverage under the ar-  
6           rangement, stating that the employer is the les-  
7           sor under the arrangement.

8           “(B) INFORMED CONSENT.—Each such  
9           applicant signs a written statement consenting  
10          to the employment relationship with the lessor.

11          “(C) INFORMED RECRUITMENT OF LES-  
12          SEE’S EMPLOYEES.—In any case in which the  
13          lessor offers employment to an employee of a  
14          lessee under the arrangement, the lessor in-  
15          forms each employee in writing that his or her  
16          acceptance of employment with the lessor is vol-  
17          untary and that refusal of such offer will not be  
18          deemed to be resignation from or abandonment  
19          of current employment.

20          “(4) REQUISITE EMPLOYER-EMPLOYEE RELA-  
21          TIONSHIP UNDER ARRANGEMENT.—Under the em-  
22          ployer-employee relationship with the employees of  
23          the lessor—

1           “(A) the lessor retains the ultimate author-  
2           ity to hire, terminate, and reassign such em-  
3           ployees,

4           “(B) the lessor is responsible for the pay-  
5           ment of wages, payroll-related taxes, and em-  
6           ployee benefits, without regard to payment by  
7           the lessee to the lessor for its services,

8           “(C) the lessor maintains the right of di-  
9           rection and control over its employees, except to  
10          the extent that the lessee is responsible for su-  
11          pervision of the work performed consistent with  
12          the lessee’s responsibility for its product or  
13          service, and

14          “(D) in accordance with section 301(a) of  
15          the Labor Management Relations Act, 1947 (29  
16          U.S.C. 185(a)), the lessor retains in the ab-  
17          sence of an applicable collective bargaining  
18          agreement, the right to enter into arbitration  
19          and to decide employee grievances, and

20          “(E) no owner, officer, or director of, or  
21          partner in, a lessee is an employee of the lessor,  
22          and not more than 10 percent of the individuals  
23          covered under the arrangement consist of own-  
24          ers, officers, or directors of, or partners in,  
25          such a lessee (or any combination thereof).

1 “(b) DEFINITIONS.—For purposes of this section—

2 “(1) LESSOR.—The term ‘lessor’ means the  
3 business or other entity from which services of indi-  
4 viduals are obtained under an employee leasing  
5 health care arrangement.

6 “(2) LESSEE.—The term ‘lessee’ means a busi-  
7 ness or other entity which receives the services of in-  
8 dividuals provided under an employee leasing health  
9 care arrangement.”.

10 (2) CLERICAL AMENDMENT.—The table of con-  
11 tents in section 1 of such Act (as amended by sec-  
12 tion 1401(d)) is further amended by inserting after  
13 the item relating to section 711 the following new  
14 item:

“Sec. 712. Employee leasing health care arrangements.”.

15 **SEC. 1406. ENFORCEMENT PROVISIONS RELATING TO MUL-**  
16 **TIPLE EMPLOYER WELFARE ARRANGEMENTS**  
17 **AND EMPLOYEE LEASING HEALTH CARE AR-**  
18 **RANGEMENTS.**

19 (a) ENFORCEMENT OF FILING REQUIREMENTS.—  
20 Section 502 of the Employee Retirement Income Security  
21 Act of 1974 (29 U.S.C. 1132) is amended—

22 (1) in subsection (a)(6), by striking “subsection  
23 (c)(2) or (i) or (l)” and inserting “paragraph (2) or  
24 (4) of subsection (c) or subsection (i) or (l)”; and



1           (2) by adding at the end of subsection (c) the  
2           following new paragraph:

3           “(4) The Secretary may assess a civil penalty against  
4           any person of up to \$1,000 a day from the date of such  
5           person’s failure or refusal to file the information required  
6           to be filed with the Secretary under section 101(g).”.

7           (b) ACTIONS BY STATES IN FEDERAL COURT.—Sec-  
8           tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

9           (1) in paragraph (5), by striking “or” at the  
10          end;

11          (2) in paragraph (6), by striking the period and  
12          inserting “, or”; and

13          (3) by adding at the end the following:

14          “(7) by a State official having authority under  
15          the law of such State to enforce the laws of such  
16          State regulating insurance, to enjoin any act or  
17          practice which violates any provision of part 7 which  
18          such State has the power to enforce under part 7.”.

19          (c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
20          MISREPRESENTATIONS.—Section 501 of such Act (29  
21          U.S.C. 1131) is amended—

22          (1) by inserting “(a)” after “SEC. 501.”; and

23          (2) by adding at the end the following new sub-  
24          section:

1       “(b) Any person who, either willfully or with willful  
2 blindness, falsely represents, to any employee, any employ-  
3 ee’s beneficiary, any employer, the Secretary, or any State,  
4 an arrangement established or maintained for the purpose  
5 of offering or providing any benefit described in section  
6 3(1) to employees or their beneficiaries as—

7               “(1) being a certified multiple employer health  
8 plan (as defined in section 701(9)),

9               “(2) being an employee leasing health care ar-  
10 rangement under a certification granted under part  
11 7, or

12               “(3) having been established or maintained  
13 under or pursuant to a collective bargaining agree-  
14 ment,

15 shall, upon conviction, be imprisoned not more than five  
16 years, be fined under title 18, United States Code, or  
17 both.”.

18       (d) CEASE ACTIVITIES ORDERS.—Section 502 of  
19 such Act (29 U.S.C. 1132) is amended by adding at the  
20 end the following new subsection:

21       “(m)(1) Subject to paragraph (2), upon application  
22 by the Secretary showing the operation, promotion, or  
23 marketing of a multiple employer welfare arrangement  
24 providing benefits consisting of medical care described in  
25 section 607(1) that—

1           “(A) is not licensed, registered, or otherwise ap-  
2       proved under the insurance laws of the States in  
3       which the arrangement offers or provides benefits, or

4           “(B) is not operating in accordance with the  
5       terms of a certification granted by the Secretary  
6       under part 7,

7       a district court of the United States shall enter an order  
8       requiring that the arrangement cease activities.

9       “(2) Paragraph (1) shall not apply in the case of a  
10      multiple employer welfare arrangement if the arrangement  
11      shows that—

12           “(A) coverage under it is fully insured, within  
13      the meaning of section 701(8),

14           “(B) it is licensed, registered, or otherwise ap-  
15      proved in each State in which it offers or provides  
16      benefits, except to the extent that such State does  
17      not require licensing, registration, or approval of  
18      multiple employer welfare arrangements under which  
19      all coverage is fully insured, and

20           “(C) with respect to each such State, it is oper-  
21      ating in accordance with applicable State insurance  
22      laws that are not superseded under section 514.

23       “(3) The court may grant such additional equitable  
24      or remedial relief, including any relief available under this  
25      title, as it deems necessary to protect the interests of the

1 public and of persons having claims for benefits against  
2 the arrangement.”.

3 (e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—  
4 Section 503 of such Act (29 U.S.C. 1133) is amended by  
5 adding at the end (after and below paragraph (2)) the fol-  
6 lowing new sentence: “The terms of each multiple em-  
7 ployer welfare arrangement to which this section applies  
8 and which provides benefits consisting of medical care de-  
9 scribed in section 607(1) shall require the operating com-  
10 mittee or the named fiduciary (as applicable) to ensure  
11 that the requirements of this section are met in connection  
12 with claims filed under the arrangement.”.

13 **SEC. 1407. FILING REQUIREMENTS FOR MULTIPLE EM-**  
14 **PLOYER WELFARE ARRANGEMENTS PROVID-**  
15 **ING HEALTH BENEFITS.**

16 Section 101 of the Employee Retirement Income Se-  
17 curity Act of 1974 (29 U.S.C. 1021) is amended—

18 (1) by redesignating subsection (g) as sub-  
19 section (h); and

20 (2) by inserting after subsection (f) the follow-  
21 ing new subsection:

22 “(g)(1) Each multiple employer welfare arrangement  
23 shall file with the Secretary a registration statement de-  
24 scribed in paragraph (2) within 60 days before commenc-  
25 ing operations (in the case of an arrangement commencing

1 operations on or after January 1, 1997) and no later than  
2 February 15 of each year (in the case of an arrangement  
3 in operation since the beginning of such year), unless, as  
4 of the date by which such filing otherwise must be made,  
5 such arrangement provides no benefits consisting of medi-  
6 cal care described in section 607(1).

7 “(2) Each registration statement—

8 “(A) shall be filed in such form, and contain  
9 such information concerning the multiple employer  
10 welfare arrangement and any persons involved in its  
11 operation (including whether coverage under the ar-  
12 rangement is fully insured), as shall be provided in  
13 regulations which shall be prescribed by the Sec-  
14 retary, and

15 “(B) if coverage under the arrangement is not  
16 fully insured, shall contain a certification that copies  
17 of such registration statement have been transmitted  
18 by certified mail to—

19 “(i) in the case of an arrangement which  
20 is a certified multiple employer health plan (as  
21 defined in section 701(9)), the State insurance  
22 commissioner of the domicile State of such ar-  
23 rangement, or

24 “(ii) in the case of an arrangement which  
25 is not a certified multiple employer health plan,

1           the State insurance commissioner of each State  
2           in which the arrangement is located.

3           “(3) The person or persons responsible for filing the  
4 annual registration statement are—

5           “(A) the trustee or trustees so designated by  
6 the terms of the instrument under which the mul-  
7 tiple employer welfare arrangement is established or  
8 maintained, or

9           “(B) in the case of a multiple employer welfare  
10 arrangement for which the trustee or trustees can-  
11 not be identified, or upon the failure of the trustee  
12 or trustees of an arrangement to file, the person or  
13 persons actually responsible for the acquisition, dis-  
14 position, control, or management of the cash or  
15 property of the arrangement, irrespective of whether  
16 such acquisition, disposition, control, or management  
17 is exercised directly by such person or persons or  
18 through an agent designated by such person or  
19 persons.

20           “(4) Any agreement entered into under section  
21 506(c) with a State as the primary domicile State with  
22 respect to any multiple employer welfare arrangement  
23 shall provide for simultaneous filings of reports required  
24 under this subsection with the Secretary and with the  
25 State insurance commissioner of such State.”.

1 **SEC. 1408. COOPERATION BETWEEN FEDERAL AND STATE**  
2 **AUTHORITIES.**

3 Section 506 of the Employee Retirement Income Se-  
4 curity Act of 1974 (29 U.S.C. 1136) is amended by adding  
5 at the end the following new subsection:

6 “(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE  
7 EMPLOYER WELFARE ARRANGEMENTS.—

8 “(1) STATE ENFORCEMENT.—

9 “(A) AGREEMENTS WITH STATES.—A  
10 State may enter into an agreement with the  
11 Secretary for delegation to the State of some or  
12 all of the Secretary’s authority under sections  
13 502 and 504 to enforce the provisions of this  
14 title applicable to multiple employer welfare ar-  
15 rangements which are or have been certified  
16 multiple employer health plans (as defined in  
17 section 701(9)). The Secretary shall enter into  
18 the agreement if the Secretary determines that  
19 the delegation provided for therein would not  
20 result in a lower level or quality of enforcement  
21 of the provisions of this title.

22 “(B) DELEGATIONS.—Any department,  
23 agency, or instrumentality of a State to which  
24 authority is delegated pursuant to an agree-  
25 ment entered into under this paragraph may, if  
26 authorized under State law and to the extent

1 consistent with such agreement, exercise the  
2 powers of the Secretary under this title which  
3 relate to such authority.

4 “(C) CONCURRENT AUTHORITY OF THE  
5 SECRETARY.—If the Secretary delegates author-  
6 ity to a State in an agreement entered into  
7 under subparagraph (A), the Secretary may  
8 continue to exercise such authority concurrently  
9 with the State.

10 “(D) RECOGNITION OF PRIMARY DOMICILE  
11 STATE.—In entering into any agreement with a  
12 State under subparagraph (A), the Secretary  
13 shall ensure that, as a result of such agreement  
14 and all other agreements entered into under  
15 subparagraph (A), only one State will be recog-  
16 nized, with respect to any particular multiple  
17 employer welfare arrangement, as the primary  
18 domicile State to which authority has been dele-  
19 gated pursuant to such agreements.

20 “(2) ASSISTANCE TO STATES.—The Secretary  
21 shall—

22 “(A) provide enforcement assistance to the  
23 States with respect to multiple employer welfare  
24 arrangements, including, but not limited to, co-  
25 ordinating Federal and State efforts through



1 the establishment of cooperative agreements  
2 with appropriate State agencies under which  
3 the Pension and Welfare Benefits Administra-  
4 tion keeps the States informed of the status of  
5 its cases and makes available to the States in-  
6 formation obtained by it,

7 “(B) provide continuing technical assist-  
8 ance to the States with respect to issues involv-  
9 ing multiple employer welfare arrangements  
10 and this Act,

11 “(C) assist the States in obtaining from  
12 the Office of Regulations and Interpretations  
13 timely and complete responses to requests for  
14 advisory opinions on issues described in sub-  
15 paragraph (B), and

16 “(D) distribute copies of all advisory opin-  
17 ions described in subparagraph (C) to the State  
18 insurance commissioner of each State.”.

19 **SEC. 1409. EFFECTIVE DATE; TRANSITIONAL RULES.**

20 (a) **EFFECTIVE DATE.**—The amendments made by  
21 this part shall take effect January 1, 1997, except that  
22 the Secretary of Labor shall first issue regulations to carry  
23 out such amendments by not later than January 1, 1996.  
24 The Secretary shall issue all regulations necessary to carry  
25 out such amendments before the effective date thereof.

1       (b) TRANSITIONAL RULES.—If the sponsor of a mul-  
2     tiple employer welfare arrangement which, as of January  
3     1, 1996, provides benefits consisting of medical care de-  
4     scribed in section 607(1) of the Employee Retirement In-  
5     come Security Act of 1974 (29 U.S.C. 1167(1)) files with  
6     the Secretary of Labor an application for a certification  
7     under part 7 of subtitle B of title I of such Act within  
8     180 days after such date and the Secretary has not, as  
9     of 90 days after receipt of such application, found such  
10    application to be materially deficient, section 514(b)(6)(A)  
11    of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply  
12    with respect to such arrangement during the 18-month pe-  
13    riod following such date. If the Secretary determines, at  
14    any time after the date of enactment of this Act, that any  
15    such exclusion from coverage under the provisions of such  
16    section 514(b)(6)(A) of such Act of a multiple employer  
17    welfare arrangement would be detrimental to the interests  
18    of individuals covered under such arrangement, such ex-  
19    clusion shall cease as of the date of the determination.  
20    Any determination made by the Secretary under this sub-  
21    section shall be in the Secretary's sole discretion.

1 **PART 2—SIMPLIFYING FILING OF REPORTS FOR**  
2 **EMPLOYERS COVERED UNDER MULTIPLE**  
3 **EMPLOYER WELFARE ARRANGEMENTS PRO-**  
4 **VIDING FULLY INSURED COVERAGE CON-**  
5 **SISTING OF MEDICAL CARE**

6 **SEC. 1411. SINGLE ANNUAL FILING FOR ALL PARTICIPAT-**  
7 **ING EMPLOYERS.**

8 (a) IN GENERAL.—Section 110 of the Employee Re-  
9 tirement Income Security Act of 1974 (29 U.S.C. 1030),  
10 as amended by section 1401(c) of this subtitle, is amended  
11 by adding at the end the following new subsection:

12 “(d) The Secretary shall prescribe by regulation or  
13 otherwise an alternative method providing for the filing  
14 of a single annual report (as referred to in section  
15 104(a)(1)(A)) with respect to all employers who are par-  
16 ticipating employers under a multiple employer welfare ar-  
17 rangement under which all coverage consists of medical  
18 care (described in section 607(1)) and is fully insured (as  
19 defined in section 701(8)).”

20 (b) EFFECTIVE DATE.—The amendment made by  
21 subsection (a) shall take effect on the date of the enact-  
22 ment of this Act. The Secretary of Labor shall prescribe  
23 the alternative method referred to in section 110(d) of the  
24 Employee Retirement Income Security Act of 1974, as  
25 added by such amendment, within 90 days after the date  
26 of the enactment of this Act.

# **Subtitle F—Definitions; General Provisions**

## **PART 1—DEFINITIONS**

### **SEC. 1901. GENERAL DEFINITIONS.**

For purposes of this Act:

(1) APPLICABLE REGULATORY AUTHORITY.—

The term “applicable regulatory authority” means, with respect to a carrier operating in a State—

(A) the State insurance commissioner, or

(B) the Secretary, in the case described in section 1302(b)(2).

(2) FAMILY MEMBER.—

(A) IN GENERAL.—Individuals are considered to be members of a family if—

(i) they are married, or

(ii) they have a legal parent-to-child relationship (whether by natural birth or adoption), if the child is—

(I) under 19 years of age,

(II) is under 25 years of age and a full-time student, or

(III) an unmarried dependent regardless of age who is incapable of self-support because of mental or

1 physical disability which existed before  
2 age 22.

3 (B) SPECIAL RULES.—Family members—

4 (i) include an adopted child and a rec-  
5 ognized natural child;

6 (ii) include a stepchild or foster child  
7 with respect to an individual but only if  
8 the child lives with the individual in a reg-  
9 ular parent-child relationship; and

10 (iii) include such other children as the  
11 Secretary may specify, but shall not in-  
12 clude an emancipated minor.

13 (3) PRISONER.—The term “prisoner” means,  
14 as specified by the Secretary, an individual during a  
15 period of imprisonment under Federal, State, or  
16 local authority after conviction as an adult.

17 (4) SECRETARY.—The term “Secretary” means  
18 the Secretary of Health and Human Services.

19 (5) STATE.—The term “State” means the 50  
20 States, the District of Columbia, Puerto Rico, the  
21 Virgin Islands, Guam, American Samoa, and the  
22 Northern Mariana Islands.

23 **SEC. 1902. DEFINITIONS RELATING TO EMPLOYMENT.**

24 (a) APPLICATION OF ERISA DEFINITIONS.—Except  
25 as otherwise provided in this Act, terms used in this Act

1 shall have the meanings applicable to such terms under  
2 section 3 of the Employee Retirement Income Security Act  
3 of 1974 (29 U.S.C. 1002).

4 (b) ADDITIONAL DEFINITIONS.—For purposes of this  
5 title:

6 (1) COUNTABLE EMPLOYEE.—The term “count-  
7 able employee” means, with respect to an employer  
8 for a month, any employee other than an employee  
9 whose normal work week is less than 10 hours.

10 (2) LARGE EMPLOYER.—The term “large em-  
11 ployer” means an employer that is not a small em-  
12 ployer (as defined in paragraph (4)).

13 (3) QUALIFYING EMPLOYEE.—

14 (A) IN GENERAL.—The term “qualifying  
15 employee” means, with respect to an employer  
16 for a month, any employee other than—

17 (i) a part-time, seasonal, or temporary  
18 employee (as defined in subparagraph  
19 (B)); or

20 (ii) an employee who is a child de-  
21 scribed in section 1901(2)(A)(ii).

22 (B) PART-TIME, SEASONAL, OR TEM-  
23 PORARY EMPLOYEE DEFINED.—For purposes of  
24 subparagraph (A), the term “part-time, sea-  
25 sonal, or temporary employee” means any of

1           the following employees with respect to a  
2           month:

3                   (i) CERTAIN PART-TIME EMPLOY-  
4                   EES.—Any employee whose normal work  
5                   week is reasonably expected as of the first  
6                   day of such month to be less than 20  
7                   hours.

8                   (ii) SEASONAL OR TEMPORARY EM-  
9                   PLOYEES.—Any employee who is not rea-  
10                  sonably expected as of the first day of such  
11                  month to be employed by the employer for  
12                  a period of 120 consecutive days during  
13                  any 365-day period that includes such first  
14                  day.

15                  (iii) DELAY FOR CERTAIN PART-TIME  
16                  EMPLOYEES.—Any employee whose normal  
17                  work week is reasonably expected as of the  
18                  first day of such month to be at least 20  
19                  hours, but less than 35 hours, and the nor-  
20                  mal work week of the employee during the  
21                  preceding 3 months was less than 20  
22                  hours.

23           (4) SMALL EMPLOYER.—The term “small em-  
24           ployer” means, with respect to a calendar year, an  
25           employer that normally employs more than 1 but

1 less than 100 countable employees on a typical busi-  
2 ness day. For the purposes of this paragraph, the  
3 term “employee” includes a self-employed individual.  
4 For purposes of determining if an employer is a  
5 small employer, rules similar to the rules of sub-  
6 section (b) and (c) of section 414 of the Internal  
7 Revenue Code of 1986 shall apply.

8 **SEC. 1903. DEFINITIONS RELATING TO HEALTH COVERAGE,**  
9 **PLANS, AND CARRIERS.**

10 Except as otherwise provided, for purposes of this  
11 Act:

12 (1) BENCHMARK COVERAGE.—The term  
13 “benchmark coverage” means the standard option of  
14 the Blue Cross-Blue Shield plan offered under the  
15 Federal Employees Health Benefits Program under  
16 chapter 89 of title 5, United States Code, as in ef-  
17 fect during 1994.

18 (2) CARRIER.—The term “carrier” means a li-  
19 censed insurance company, an entity offering pre-  
20 paid hospital or medical services, and a health main-  
21 tenance organization, and includes a similar organi-  
22 zation regulated under State law for solvency.

23 (3) CERTIFIED MULTIPLE EMPLOYER HEALTH  
24 PLAN.—The term “certified multiple employer health  
25 plan” means a multiple employer welfare arrange-



1       ment treated as an employee welfare benefit plan by  
2       reason of a certification under part 7 of subtitle B  
3       of title I of the Employee Retirement Income Secu-  
4       rity Act of 1974 (as added by section 1401(a)).

5           (4) CLASS OF FAMILY COVERAGE.—The term  
6       “class of family coverage” means the 4 classes de-  
7       scribed in section 1021(a)(3).

8           (5) FAIR RATING AREA.—The term “fair rating  
9       area” means a geographic area identified by a State  
10      for purposes of section 1021(a)(2).

11          (6) GROUP HEALTH PLAN.—The term “group  
12      health plan” means an employee welfare benefit plan  
13      providing medical care (as defined in section 213(d)  
14      of the Internal Revenue Code of 1986) to partici-  
15      pants or beneficiaries directly or through insurance,  
16      reimbursement, or otherwise, but does not include  
17      any type of coverage excluded from the definition of  
18      a health insurance coverage under paragraph (8)(B).

19          (7) HEALTH COVERAGE.—The term “health  
20      coverage” means health insurance coverage provided  
21      by a carrier or medical care provided under a group  
22      health plan.

23          (8) HEALTH INSURANCE COVERAGE.—

24              (A) IN GENERAL.—Except as provided in  
25      subparagraph (B), the term “health insurance

1 coverage” means any hospital or medical service  
2 policy or certificate, hospital or medical service  
3 plan contract, or health maintenance organiza-  
4 tion group contract offered by a carrier.

5 (B) EXCEPTION.—Such term does not in-  
6 clude any of the following (or any combination  
7 of the following):

8 (i) Coverage only for accident, dental,  
9 vision, disability income, or long-term care  
10 insurance, or any combination thereof.

11 (ii) Medicare supplemental health in-  
12 surance.

13 (iii) Coverage issued as a supplement  
14 to liability insurance.

15 (iv) Liability insurance, including gen-  
16 eral liability insurance and automobile li-  
17 ability insurance.

18 (v) Workers’ compensation or similar  
19 insurance.

20 (vi) Automobile medical-payment in-  
21 surance.

22 (vii) Coverage for a specified disease  
23 or illness.

24 (viii) A hospital or fixed indemnity  
25 policy.

1 (ix) Coverage provided exclusively to  
2 individuals who are not eligible individuals.

3 (9) HEALTH MAINTENANCE ORGANIZATION.—  
4 The term “health maintenance organization” in-  
5 cludes, as defined in standards established under  
6 section 1103, an organization that provides health  
7 insurance coverage which meets specified standards  
8 and under which health services are offered to be  
9 provided on a prepaid, at-risk basis primarily  
10 through a defined set of providers.

11 (10) HEALTH PLAN PURCHASING ORGANIZA-  
12 TION.—The term “health plan purchasing organiza-  
13 tion” means an organization established under sub-  
14 title A of title VI.

15 (11) INDIVIDUAL/SMALL GROUP MARKET.—The  
16 term “individual/small group market” means the in-  
17 surance market offered—

18 (A) to individuals seeking health insurance  
19 coverage on behalf of themselves (and their de-  
20 pendents) insofar as no employer is seeking  
21 such coverage on behalf of the individual, and

22 (B) to small employers seeking health in-  
23 surance coverage on behalf of their employees  
24 (and their dependents),

1 regardless of whether or not such coverage is made  
2 available directly or through a multiple employer  
3 welfare arrangement, association, or otherwise.

4 (12) MANAGED CARE ARRANGEMENTS.—

5 (A) MANAGED CARE ARRANGEMENT.—The  
6 term “managed care arrangement” means, with  
7 respect to a group health plan or under health  
8 insurance coverage, an arrangement under such  
9 plan or coverage under which providers agree to  
10 provide items and services covered under the ar-  
11 rangement to individuals covered under the  
12 plan or who have such coverage.

13 (B) PROVIDER NETWORK.—The term  
14 “provider network” means, with respect to a  
15 group health plan or health insurance coverage,  
16 providers who have entered into an agreement  
17 described in subparagraph (A).

18 (13) MULTIPLE EMPLOYER WELFARE AR-  
19 RANGEMENT.—The term “multiple employer welfare  
20 arrangement” shall have the meaning applicable  
21 under section 3(40) of the Employee Retirement In-  
22 come Security Act of 1974.

23 (14) NAIC.—The term “NAIC” means the Na-  
24 tional Association of Insurance Commissioners.

1           (15) OPTIONS.—Each of the following is a  
2           “type of coverage option” in relation to standard  
3           coverage:

4                   (A) FEE-FOR-SERVICE OPTION.—Standard  
5           coverage is considered to provide a “fee-for-  
6           service option” if, regardless of whether covered  
7           individuals may receive benefits through a pro-  
8           vider network, benefits with respect to the cov-  
9           ered items and services in the coverage are  
10          made available for such items and services pro-  
11          vided through any lawful provider of such cov-  
12          ered items and services and payment is made to  
13          such a provider whether or not there is a con-  
14          tractual arrangement between the provider and  
15          the carrier or plan.

16                  (B) MANAGED CARE OPTION.—Standard  
17          coverage is considered to provide a “managed  
18          care option” if benefits with respect to the cov-  
19          ered items and services in the coverage are  
20          made available exclusively through a provider  
21          network, except in the case of emergency serv-  
22          ices and as otherwise required under law.

23                  (C) POINT-OF-SERVICE OPTION.—Standard  
24          coverage is considered to provide a “point-of-  
25          service option” if the benefits with respect to

1 covered items and services in the coverage are  
2 made available principally through a managed  
3 care arrangement, with the choice of the en-  
4 rollee to obtain such benefits for items and  
5 services provided through any lawful provider of  
6 such covered items and services. The coverage  
7 may provide for different cost sharing schedules  
8 based on whether the items and services are  
9 provided through such an arrangement or out-  
10 side such an arrangement.

11 (16) QUALIFIED HEALTH COVERAGE.—The  
12 term “qualified health coverage” has the meaning  
13 given such term in section 1101.

14 (17) STANDARD COVERAGE.—The term “stand-  
15 ard coverage” means coverage provided consistent  
16 with section 1102(a).

17 (18) STATE COMMISSIONER OF INSURANCE.—  
18 The term “State commissioner of insurance” in-  
19 cludes a State superintendent of insurance.

20 **SEC. 1904. DEFINITIONS RELATING TO RESIDENCE AND IM-**  
21 **MIGRATION STATUS.**

22 Except as otherwise provided, for purposes of this  
23 Act:

24 (1) ALIEN PERMANENTLY RESIDING IN THE  
25 UNITED STATES UNDER COLOR OF LAW.—The term

1 “alien permanently residing in the United States  
2 under color of law” means an alien lawfully admitted  
3 for permanent residence (within the meaning of sec-  
4 tion 101(a)(20) of the Immigration and Nationality  
5 Act), and includes any of the following (such status  
6 not having changed):

7 (A) An alien who is admitted as a refugee  
8 under section 207 of the Immigration and Na-  
9 tionality Act.

10 (B) An alien who is granted asylum under  
11 section 208 of such Act.

12 (C) An alien whose deportation is withheld  
13 under section 243(h) of such Act.

14 (D) An alien whose deportation is sus-  
15 pended pursuant to section 244 of such Act.

16 (E) An alien who is granted conditional  
17 entry pursuant to section 203(a)(7) of such Act  
18 as in effect before April 1, 1980.

19 (F) An alien who is admitted for tem-  
20 porary residence under section 210, 210A, or  
21 245A of such Act.

22 (G) An alien who is within a class of aliens  
23 lawfully present in the United States pursuant  
24 to any other provision of such Act, if (i) the At-  
25 torney General determines that the continued

1 presence of such class of aliens serves a human-  
2 itarian or other compelling public interest, and  
3 (ii) the Secretary determines that such interest  
4 would be further served by treating each such  
5 alien within such class as a “legal permanent  
6 resident” for purposes of this Act or who has  
7 been granted extended voluntary departure as a  
8 member of a nationality group.

9 (H) An alien who is the spouse or unmar-  
10 ried child under 21 years of age of a citizen of  
11 the United States, or the parent of such a citi-  
12 zen if the citizen is over 21 years of age, and  
13 with respect to whom an application for adjust-  
14 ment to lawful permanent residence is pending.

15 (I) An alien within such other classification  
16 of permanent resident aliens as the Secretary  
17 may establish by regulation.

18 (2) LONG-TERM NONIMMIGRANT.—The term  
19 “long-term nonimmigrant” means a nonimmigrant  
20 described in subparagraph (E), (H), (I), (K), (L),  
21 (N), (O), (Q), or (R) of section 101(a)(15) of the  
22 Immigration and Nationality Act.

23 (3) QUALIFYING INDIVIDUAL.—The term  
24 “qualifying individual” means, an individual who is



1 a resident of the United States, who is not a pris-  
2 oner, and is—

3 (A) a citizen or national of the United  
4 States;

5 (B) an alien permanently residing in the  
6 United States under color of law (as defined in  
7 paragraph (1)); or

8 (C) a long-term nonimmigrant (as defined  
9 in paragraph (2)).

10 **SEC. 1905. EFFECTIVE DATES.**

11 The requirements of this title shall apply with respect  
12 to—

13 (1) group health plans for plan years beginning  
14 on or after January 1, 1997, and

15 (2) carriers (with respect to coverage other than  
16 under a group health plan) as of January 1, 1997.

17 **PART 2—REPORT AND RECOMMENDATIONS ON**  
18 **HEALTH COVERAGE AND ACCESS**

19 **SEC. 1911. OBJECTIVE OF FULL ACCESS AND COVERAGE.**

20 It is an objective of this Act to assure by 2002 that—

21 (1) all eligible individuals in the United States  
22 have access to private or public health coverage, and

23 (2) at least 95 percent of such individuals have  
24 such coverage.

1 **SEC. 1912. REPORT AND RECOMMENDATIONS ON ACHIEVE-**  
 2 **MENT OF OBJECTIVE FOR HEALTH COV-**  
 3 **ERAGE AND ACCESS.**

4 (a) STUDY.—The Secretary shall monitor and evalu-  
 5 ate the extent to which eligible individuals in the United  
 6 States have access to health coverage and have health cov-  
 7 erage.

8 (b) REPORT.—Not later than January 31, 2002, the  
 9 Secretary shall submit to Congress a report on the evalua-  
 10 tion conducted under subsection (a). The Secretary shall  
 11 include in the report a determination of whether the objec-  
 12 tive described in section 1911 has been met.

13 (c) RECOMMENDATIONS.—If the Secretary deter-  
 14 mines that such objective has not been met, the Secretary  
 15 shall include in the report such recommendations as may  
 16 be appropriate to achieve the objective at the earliest pos-  
 17 sible date.

18 **TITLE II—REMOVAL OF FINAN-**  
 19 **CIAL BARRIERS TO ACCESS**

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**Subtitle B—Premium and Cost-Sharing Subsidy Program for**  
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“TITLE XXI—STATE ACUTE CARE BENEFITS PROGRAMS FOR LOW-INCOME INDIVIDUALS; FINANCING FAILSAFE MECHANISM

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Sec. 2102. Operation of program as State plan requirement under medicaid.

Sec. 2103. Application of miscellaneous provisions.

## 1     **Subtitle A—Tax Deductibility for** 2     **Individuals and Self-Employed**

### 3     **SEC. 2001. DEDUCTION FOR HEALTH INSURANCE COSTS OF** 4                     **SELF-EMPLOYED INDIVIDUALS INCREASED** 5                     **AND MADE PERMANENT.**

6         (a) IN GENERAL.—Paragraph (1) of section 162(l)  
 7 of the Internal Revenue Code of 1986 (relating to special  
 8 rules for health insurance costs of self-employed individ-  
 9 uals) is amended by striking “25 percent” and inserting  
 10 “the applicable percentage”.

1 (b) DEDUCTION MADE PERMANENT; APPLICABLE  
 2 PERCENTAGE.—Paragraph (6) of section 162(l) of such  
 3 Code is amended to read as follows:

4 “(6) APPLICABLE PERCENTAGE.—For purposes  
 5 of paragraph (1)—

<b>“In the case of taxable years beginning in calendar year:</b>	<b>The applicable percentage is:</b>
1994, 1995, 1996, 1997, or 1998 .....	25 percent
1999 .....	50 percent
2000 or thereafter .....	100 percent.”

6 (c) EFFECTIVE DATE.—The amendments made by  
 7 this section shall apply to taxable years beginning after  
 8 December 31, 1993.

9 **SEC. 2002. DEDUCTION FOR HEALTH INSURANCE COSTS OF**  
 10 **INDIVIDUALS WHO ARE NOT SELF-EM-**  
 11 **PLOYED.**

12 (a) IN GENERAL.—Part VII of subchapter B of chap-  
 13 ter 1 of the Internal Revenue Code of 1986 (relating to  
 14 additional itemized deductions) is amended by redesignat-  
 15 ing section 220 as section 221 and by inserting after sec-  
 16 tion 219 the following new section:

17 **“SEC. 220. HEALTH INSURANCE COSTS OF INDIVIDUALS**  
 18 **WHO ARE NOT SELF-EMPLOYED.**

19 “(a) IN GENERAL.—In the case of an individual who  
 20 is not a self-employed individual (as defined in section  
 21 401(c)(1)), there shall be allowed as a deduction an  
 22 amount equal to 25 percent of the amount paid during

1 the taxable year for insurance which constitutes medical  
2 care for the taxpayer, his spouse, and dependents.

3 “(b) COORDINATION WITH DEDUCTION FOR SELF-  
4 EMPLOYED INDIVIDUALS.—The amount which would (but  
5 for this paragraph) be allowed as a deduction under sub-  
6 section (a) for the taxable year shall be reduced (but not  
7 below zero) by the amount (if any) allowed as a deduction  
8 under section 162(l) for such taxable year.

9 “(c) OTHER COVERAGE.—Subsection (a) shall not  
10 apply to any taxpayer for any calendar month for which  
11 the taxpayer is eligible to participate in any subsidized  
12 health plan maintained by any employer of the taxpayer  
13 or of the spouse of the taxpayer.

14 “(d) COORDINATION WITH MEDICAL DEDUCTION,  
15 ETC.—Any amount paid by a taxpayer for insurance to  
16 which subsection (a) applies shall not be taken into ac-  
17 count in computing the amount allowable to the taxpayer  
18 as a deduction under section 213(a).”

19 (b) DEDUCTION ALLOWED WHETHER OR NOT TAX-  
20 PAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a)  
21 of section 62 of such Code is amended by adding at the  
22 end the following new paragraph:

23 “(16) HEALTH INSURANCE COSTS.—The deduc-  
24 tion allowed by section 220.”

1 (c) CLERICAL AMENDMENT.—The table of sections  
2 for part VII of subchapter B of chapter 1 of such Code  
3 is amended by striking the last item and inserting the fol-  
4 lowing new items:

“Sec. 220. Health insurance costs of individuals who are not self-  
employed.

“Sec. 221. Cross reference.”

5 (d) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to taxable years beginning after  
7 December 31, 1995.

8 **SEC. 2003. RESTRICTIONS ON HEALTH BENEFITS PRO-**  
9 **VIDED THROUGH CAFETERIA PLANS AND**  
10 **FLEXIBLE SPENDING ARRANGEMENTS.**

11 (a) FLEXIBLE SPENDING ARRANGEMENTS.—Section  
12 106 of the Internal Revenue Code of 1986 (relating to  
13 contributions by employer to accident and health plans)  
14 is amended to read as follows:

15 **“SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT**  
16 **AND HEALTH PLANS.**

17 “(a) GENERAL RULE.—Except as otherwise provided  
18 in this section, gross income of an employee does not in-  
19 clude employer-provided coverage under an accident or  
20 health plan.

21 “(b) INCLUSION OF CERTAIN BENEFITS PROVIDED  
22 THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—  
23 Gross income of an employee shall include such employer-  
24 provided coverage which is provided through a flexible

1 spending or similar arrangement if any amount of deduct-  
2 ible, copayment, coinsurance, or similar cost-sharing may  
3 be paid for or reimbursed under such arrangement.”

4 (b) CAFETERIA PLANS.—Subsection (f) of section  
5 125 of such Code (defining qualified benefits) is amended  
6 by adding at the end thereof the following new sentence:  
7 “Such term shall not include any benefits or coverage  
8 under an accident or health plan if any amount of deduct-  
9 ible, copayment, coinsurance, or similar cost-sharing  
10 under such a plan, or more than 20 percent of any pre-  
11 mium (or comparable amount in the case of a plan not  
12 provided through insurance) for such a plan, may be paid  
13 for or reimbursed under the cafeteria plan.”

14 (c) EMPLOYMENT TAX TREATMENT.—

15 (1) SOCIAL SECURITY TAX.—

16 (A) Subsection (a) of section 3121 of such  
17 Code is amended by inserting after paragraph  
18 (21) the following new sentence:

19 “Nothing in paragraph (2) shall exclude from the term  
20 ‘wages’ any amount which is required to be included in  
21 gross income under section 106(b).”

22 (B) Subsection (a) of section 209 of the  
23 Social Security Act is amended by inserting  
24 after paragraph (21) the following new sen-  
25 tence:

1 “Nothing in paragraph (2) shall exclude from the term  
2 ‘wages’ any amount which is required to be included in  
3 gross income under section 106(b) of the Internal Revenue  
4 Code of 1986.”

5 (2) RAILROAD RETIREMENT TAX.—Paragraph  
6 (1) of section 3231(e) of such Code is amended by  
7 adding at the end thereof the following new sen-  
8 tence: “Nothing in clause (i) of the second sentence  
9 of this paragraph shall exclude from the term ‘com-  
10 pensation’ any amount which is required to be in-  
11 cluded in gross income under section 106(b).”

12 (3) UNEMPLOYMENT TAX.—Subsection (b) of  
13 section 3306 of such Code is amended by inserting  
14 after paragraph (16) the following new sentence:  
15 “Nothing in paragraph (2) shall exclude from the term  
16 ‘wages’ any amount which is required to be included in  
17 gross income under section 106(b).”

18 (4) WAGE WITHHOLDING.—Subsection (a) of  
19 section 3401 of such Code is amended by adding at  
20 the end thereof the following new sentence:  
21 “Nothing in the preceding provisions of this subsection  
22 shall exclude from the term ‘wages’ any amount which is  
23 required to be included in gross income under section  
24 106(b).”



1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall take effect on January 1, 1996.

3 **Subtitle B—Premium and Cost-**  
4 **Sharing Subsidy Program for**  
5 **Low-Income Individuals**

6 **SEC. 2100. DESCRIPTION OF TRANSITION FROM CURRENT**  
7 **MEDICAID SYSTEM TO NEW ACUTE CARE**  
8 **LOW-INCOME SUBSIDY PROGRAMS FOR AFDC**  
9 **RECIPIENTS AND NON-CASH MEDICAID BENE-**  
10 **FICIARIES.**

11 The amendments made by this subtitle and title III  
12 provide for a transition from the current medicaid system  
13 to a new system of acute care low-income assistance  
14 through the following:

15 (1) IMMEDIATE MEDICAID REFORMS.—During  
16 1995, 1996, and 1997, States are permitted—

17 (A) to enroll medicaid recipients under co-  
18 ordinated care arrangements, but are restricted  
19 from eliminating eligibility categories currently  
20 in effect; and

21 (B) to provide certain classes of acute care  
22 services to such recipients through a State sup-  
23 plemental benefits program,  
24 under the amendments made by section 3101.

1           (2) ESTABLISHMENT OF NEW PREMIUM AND  
2           COST-SHARING SUBSIDY PROGRAM AND SUPPLE-  
3           MENTAL BENEFITS PROGRAM AND INTEGRATION OF  
4           AFDC AND NON-CASH BENEFICIARIES.—Beginning  
5           January 1, 1998—

6                   (A) States are required to establish a new  
7                   premium and cost-sharing subsidy program  
8                   under part A of title XXI of the Social Security  
9                   Act (as added by section 2101); and

10                   (B) with respect to AFDC and non-cash  
11                   medicaid beneficiaries and other low-income in-  
12                   dividuals—

13                           (i) States are required to provide for  
14                           premium and cost-sharing assistance for  
15                           core benefits for premium and cost-sharing  
16                           assistance eligible individuals through that  
17                           program and additional benefits through a  
18                           supplemental benefits grant program under  
19                           part B of title XXI of the Social Security  
20                           Act (as added by section 3101), and

21                           (ii) States will no longer provide such  
22                           individuals with medicaid coverage for  
23                           acute care services.

1 **SEC. 2101. STATE PREMIUM AND COST-SHARING SUBSIDY**  
2 **PROGRAMS.**

3 (a) REQUIREMENTS FOR PROGRAMS.—The Social Se-  
4 curity Act is amended by adding at the end the following  
5 new title:

6 “TITLE XXI—STATE ACUTE CARE BENEFITS  
7 PROGRAMS FOR LOW-INCOME INDIVID-  
8 UALS; FINANCING FAILSAFE MECHANISM

9 “PART A—STATE PREMIUM AND COST-SHARING  
10 SUBSIDY PROGRAMS

11 **“SEC. 2101. ESTABLISHMENT OF STATE PROGRAMS.**

12 “(a) IN GENERAL.—As a requirement under section  
13 1902(a)(65), effective January 1, 1998, each State shall  
14 establish and maintain a premium and cost-sharing sub-  
15 sidy program (in this title referred to as a ‘State subsidy  
16 program’) that provides for—

17 “(1) premium assistance described in section  
18 2103 to premium assistance eligible individuals de-  
19 scribed in section 2102(a) in accordance with this  
20 part,

21 “(2) cost-sharing assistance described in section  
22 2103 to cost-sharing assistance eligible individuals  
23 described in section 2102(b) in accordance with this  
24 part, and

25 “(3) State maintenance-of-effort payments in  
26 accordance with section 2107.

1       “(b) AVAILABILITY OF FUNDS.—Each State with a  
2 State subsidy program approved under this part is enti-  
3 tled, for calendar quarters beginning on or after January  
4 1, 1998, to payment under section 2106.

5       “(c) APPROVAL OF STATE PROGRAMS.—The Sec-  
6 retary may not approve a State subsidy program unless  
7 the State has submitted a detailed description that speci-  
8 fies the form and manner in which it will carry out the  
9 program and the Secretary finds that the program meets  
10 the requirements of this part.

11       “(d) DESIGNATION OF STATE AGENCY.—A State shall  
12 designate an appropriate State agency to administer the  
13 State subsidy program. Such agency shall be the same  
14 agency as the agency designated to administer the State  
15 supplemental medical benefits program under part B.

16       **“SEC. 2102. ELIGIBILITY.**

17       “(a) ASSISTANCE.—

18               “(1) PREMIUM ASSISTANCE.—Each premium  
19 assistance eligible individual (as defined in sub-  
20 section (b)) is entitled to premium assistance under  
21 section 2103(a)(1).

22               “(2) COST-SHARING ASSISTANCE.—Each cost-  
23 sharing assistance eligible individual (as defined in  
24 subsection (c)) is entitled to cost-sharing assistance  
25 described in section 2103(a)(2).

1       “(b) PREMIUM ASSISTANCE ELIGIBLE INDIVIDUAL  
2     DEFINED.—

3               “(1) IN GENERAL.—In this title, subject to the  
4       succeeding provisions of this section and part C, the  
5       term ‘premium assistance eligible individual’ means  
6       an individual who has been determined under section  
7       2104 to have family modified adjusted income below  
8       the following applicable percentage of the applicable  
9       poverty line (as defined in section 2147(2)):

<b>“Calendar year:</b>	<b>Applicable percentage:</b>
1998 .....	100
1999 .....	115
2000 .....	130
2001 .....	145
2002 .....	160
2003 .....	175
2004 .....	200

10              “(2) SPECIAL RULE FOR CHILDREN AND PREG-  
11       NANT WOMEN.—In this title, subject to the succeed-  
12       ing provisions of this section and part C, the term  
13       ‘premium assistance eligible individual’ includes an  
14       individual who is a child under 19 years of age or  
15       a pregnant woman and who has been determined  
16       under section 2104 to have family modified adjusted  
17       income below the following applicable percentage of  
18       the applicable poverty line:

<b>“Calendar year:</b>	<b>Applicable percentage:</b>
1998 .....	185
1999 .....	185
2000 .....	185
2001 .....	185

2002 .....	185
2003 .....	200
2004 .....	240

1       “(c) COST-SHARING ASSISTANCE ELIGIBLE INDIVID-  
2 UAL DEFINED.—In this title, subject to the succeeding  
3 provisions of this section and part C, the term ‘cost-shar-  
4 ing assistance eligible individual’ means an individual who  
5 has been determined under section 2104 to have family  
6 modified adjusted income below 100 percent of the appli-  
7 cable poverty line.

8       “(d) EXCLUSION OF CERTAIN INDIVIDUALS.—In this  
9 title—

10           “(1) IN GENERAL.—The terms ‘premium assist-  
11 ance eligible individual’ and ‘cost-sharing assistance  
12 eligible individual’ do not include, with respect to a  
13 month, any of the following individuals:

14           “(A) MEDICARE BENEFICIARY.—An indi-  
15 vidual who is entitled to benefits under part A  
16 or B of title XVIII for the month.

17           “(B) SSI RECIPIENT.—An individual who  
18 is an SSI recipient (as defined in paragraph  
19 (2)) for the month.

20           “(C) INMATES.—An individual who as of  
21 the first day of the month is an inmate of a  
22 public institution (except as a patient of a med-  
23 ical institution).

1           “(D) CERTAIN ALIENS.—An alien who is  
2           not lawfully admitted for permanent residence  
3           or not otherwise permanently residing in the  
4           United States under color of law (as defined in  
5           paragraph (3)).

6           “(E) NONRESIDENTS.—An individual who  
7           is not residing in any State.

8           “(2) SSI RECIPIENT.—The term ‘SSI recipient’  
9           means, for a month, an individual—

10           “(A) with respect to whom supplemental  
11           security income benefits are being paid under  
12           title XVI for the month,

13           “(B) who is receiving a supplemental pay-  
14           ment under section 1616 or under section 212  
15           of Public Law 93–66 for the month,

16           “(C) who is receiving monthly benefits  
17           under section 1619(a) (whether or not pursuant  
18           to section 1616(c)(3)) for the month, or

19           “(D) who is treated under section 1619(b)  
20           as receiving supplemental security income bene-  
21           fits in a month for purposes of title XIX.

22           “(3) ALIEN PERMANENTLY RESIDING IN THE  
23           UNITED STATES UNDER COLOR OF LAW.—The term  
24           ‘alien permanently residing in the United States  
25           under color of law’ means an alien lawfully admitted

1 for permanent residence (within the meaning of sec-  
2 tion 101(a)(20) of the Immigration and Nationality  
3 Act), and includes any of the following:

4 “(A) An alien who is admitted as a refugee  
5 under section 207 of the Immigration and Na-  
6 tionality Act.

7 “(B) An alien who is granted asylum  
8 under section 208 of such Act.

9 “(C) An alien whose deportation is with-  
10 held under section 243(h) of such Act.

11 “(D) An alien whose deportation is sus-  
12 pended under section 244 of such Act.

13 “(E) An alien who is granted conditional  
14 entry pursuant to section 203(a)(7) of such  
15 Act, as in effect before April 1, 1980.

16 “(F) An alien who is admitted for tem-  
17 porary residence under section 210, 210A, or  
18 245A of such Act.

19 “(G) An alien who has been paroled into  
20 the United States under section 212(d)(5) of  
21 such Act for an indefinite period or who has  
22 been granted extended voluntary departure as a  
23 member of a nationality group.

24 “(H) An alien who is the spouse or unmar-  
25 ried child under 21 years of age of a citizen of



1           the United States, or the parent of such a citi-  
2           zen if the citizen is over 21 years of age, and  
3           with respect to whom an application for adjust-  
4           ment to lawful permanent residence is pending.

5           “(e) PROTECTION OF CURRENT BENEFICIARIES.—

6           “(1) IN GENERAL.—In this title, the term ‘pre-  
7           mium assistance eligible individual’ also includes,  
8           with respect to a State as of December 31, 1997, an  
9           individual described in paragraph (2) whose eligi-  
10          bility for premium assistance has not terminated  
11          under paragraph (3).

12          “(2) CURRENT BENEFICIARIES DESCRIBED.—  
13          An individual described in this paragraph is an indi-  
14          vidual who—

15                  “(A) is not excluded under subsection (d),

16                  “(B) is enrolled to receive medical assist-  
17                  ance under the State plan under title XIX (and  
18                  for which Federal financial participation was  
19                  available) as of December 31, 1997, and

20                  “(C) would remain enrolled to receive such  
21                  assistance under the State plan under title XIX  
22                  but for amendments made by the Bipartisan  
23                  Health Care Reform Act of 1994.

1           “(3) LIMITATION.—An individual is a premium  
2       assistance eligible individual pursuant to this sub-  
3       section only until the earlier of—

4           “(A) June 30, 1998, or

5           “(B) the first date after December 31,  
6       1997, on which the individual’s eligibility for  
7       medical assistance under the State plan under  
8       title XIX would have been terminated if the  
9       amendments made by the Bipartisan Health  
10      Care Reform Act of 1994 had not been enacted.

11   **“SEC. 2103. PREMIUM AND COST-SHARING ASSISTANCE.**

12       “(a) IN GENERAL.—

13           “(1) PREMIUM ASSISTANCE.—

14           “(A) IN GENERAL.—The premium assist-  
15      ance under a State subsidy program shall be in  
16      the form of a premium assistance certificate  
17      that is in the amount computed under sub-  
18      section (b) and that may be applied toward  
19      qualifying coverage (as defined in subparagraph  
20      (B)). A carrier or group health plan providing  
21      such coverage that is tendered such a certificate  
22      with respect to an individual shall reduce the  
23      amount of the premium by the amount of the  
24      certificate, except as provided in subsection  
25      (c)(1)(C).

1 “(B) QUALIFYING COVERAGE DEFINED.—

2 For purposes of this part—

3 “(i) IN GENERAL.—Except as pro-  
4 vided in clause (ii), the term ‘qualifying  
5 coverage’ means standard coverage de-  
6 scribed in section 1102 of the Bipartisan  
7 Health Care Reform Act of 1994.

8 “(ii) OPTIONAL USE OF HIGH-DE-  
9 DUCTIBLE COVERAGE.—At the election of  
10 a premium assistance eligible individual,  
11 the term ‘qualifying coverage’ includes  
12 high-deductible coverage described in sec-  
13 tion 1103 of the Bipartisan Health Care  
14 Reform Act of 1994 with respect to an in-  
15 dividual, but only if the individual—

16 “(I) has been determined under  
17 section 2104 to have family modified  
18 adjusted income not less than 100  
19 percent of the applicable poverty line  
20 (or in the case of an individual de-  
21 scribed in section 2102(a)(2), 185  
22 percent of such applicable poverty  
23 line), and

24 “(II) demonstrates to the satis-  
25 faction of the State that the individual

1 meets the requirements of section  
2 1101(b)(2) of the Bipartisan Health  
3 Care Reform Act of 1994 (relating to  
4 requirement for available assets).

5 “(iii) TREATMENT OF VA HEALTH  
6 COVERAGE.—For purposes of this part, VA  
7 health coverage (as defined in section  
8 1801(2) of title 38, United States Code)  
9 provided by the Department of Veterans  
10 Affairs shall be considered to be standard  
11 health insurance coverage (referred to in  
12 subparagraph (A)) provided by a carrier.

13 “(2) COST-SHARING ASSISTANCE.—The cost-  
14 sharing assistance under a State subsidy program  
15 shall be in the form of a cost-sharing assistance cer-  
16 tificate (or other means) that may be applied with  
17 respect to standard coverage. A carrier providing  
18 health insurance coverage or a group health plan  
19 that is tendered such a certificate with respect to an  
20 individual shall reduce the cost-sharing otherwise  
21 imposed with respect to health coverage to amounts  
22 that are nominal (as specified by the State, consist-  
23 ent with the regulations established to carry out sec-  
24 tion 1916(a)(3)) and shall not impose any cost-shar-  
25 ing in the case of preventive benefits described in

1 section 1102(b)(4) of the Bipartisan Health Care  
2 Reform Act of 1994.

3 “(3) CONSOLIDATED AND ELECTRONIC CER-  
4 TIFICATES.—Nothing in this section shall be con-  
5 strued as preventing a State from—

6 “(A) in the case of an individual who is  
7 both a premium assistance eligible individual  
8 and a cost-sharing assistance eligible individual,  
9 from consolidating the premium and cost-shar-  
10 ing certificates of the individual, and

11 “(B) providing premium and cost-sharing  
12 assistance certificates through electronic or  
13 other means.

14 “(b) AMOUNT OF PREMIUM ASSISTANCE.—

15 “(1) AMOUNT OF ASSISTANCE.—

16 “(A) IN GENERAL.—Subject to subpara-  
17 graph (B), the amount of premium assistance  
18 under this subsection for a month for an indi-  
19 vidual is the lesser of—

20 “(i) the premium assistance reference  
21 amount determined under paragraph (2),  
22 or

23 “(ii) the amount of the monthly pre-  
24 mium for the qualifying coverage provided  
25 to the individual.

1           “(B) TAKING INTO ACCOUNT EMPLOYER  
2           CONTRIBUTIONS.—If an employer is making a  
3           contribution for the health coverage of a pre-  
4           mium assistance eligible individual, the amount  
5           of the premium assistance under this subsection  
6           for a month shall not exceed the amount by  
7           which the premium amount described in sub-  
8           paragraph (A)(ii) exceeds the amount of the  
9           employer contribution.

10          “(2) PREMIUM ASSISTANCE REFERENCE  
11          AMOUNT DETERMINED.—

12               “(A) IN GENERAL.—Subject to paragraph  
13               (4), the premium assistance reference amount  
14               determined under this paragraph is an amount  
15               equal to  $\frac{1}{12}$  of the premium assistance percent-  
16               age (as defined in paragraph (3)) multiplied by  
17               the weighted average annual premium (deter-  
18               mined in accordance with subparagraph (B))  
19               for the individual’s family class of enrollment  
20               for qualified standard health coverage offered in  
21               the fair rating area (as defined in section 1903  
22               of the Bipartisan Health Care Reform Act of  
23               1994) in the individual/small group market in  
24               which the individual resides.

1           “(B) DETERMINATION OF WEIGHTED AV-  
2           ERAGE ANNUAL PREMIUM.—For purposes of  
3           subparagraph (A), the weighted average annual  
4           premium for a family class of enrollment for  
5           qualified standard health coverage shall be  
6           based on the number of families (or individuals  
7           in the case of the individual class of enrollment)  
8           so covered in the class and area involved.

9           “(C) FAMILY CLASS OF ENROLLMENT.—In  
10          this paragraph, the term ‘family class of enroll-  
11          ment’ means a class of enrollment described in  
12          section 1021(a)(3) of the Bipartisan Health  
13          Care Reform Act of 1994.

14          “(3) PREMIUM ASSISTANCE PERCENTAGE.—For  
15          purposes of this part and subject to section  
16          2141(e)(3)—

17               “(A) IN GENERAL.—Subject to subpara-  
18               graph (B), the term ‘premium assistance per-  
19               centage’ means 100 percent reduced (but not  
20               below zero) by the number of percentage points  
21               (rounded to the nearest whole number) by  
22               which such individual’s family income (ex-  
23               pressed as a percent) exceeds 100 percent of  
24               the applicable poverty line.

1           “(B) CHILDREN AND PREGNANT  
2 WOMEN.—In the case of a premium assistance  
3 eligible individual described in paragraph (2) of  
4 section 2102(b), the term ‘premium assistance  
5 percentage’ means 100 percent reduced (but  
6 not below zero) by 1 percentage point for each  
7 .55 percentage points by which such individual’s  
8 family income (expressed as a percent) exceeds  
9 185 percent of the applicable poverty line.

10           “(C) CURRENT MEDICAID BENE-  
11 FICIARIES.—In the case of an individual who is  
12 a premium assistance eligible individual pursu-  
13 ant to 2102(d), the term ‘premium assistance  
14 percentage’ means 100 percent.

15           “(4) SPECIAL RULE FOR FAMILIES WITH CHIL-  
16 DREN AND PREGNANT WOMEN.—In the case of a  
17 family consisting of premium assistance eligible indi-  
18 viduals in which the modified adjusted gross income  
19 exceeds 100 percent of the applicable poverty line,  
20 but which includes one or more individuals described  
21 in paragraph (2) of section 2102(b), the premium  
22 assistance amount may be computed in a manner  
23 (specified by the Secretary in regulations) based on  
24 the sum of separate premium amounts for family  
25 members based on individual class of enrollment,



1       rather than based on the appropriate family class of  
2       enrollment.

3       “(c) PAYMENTS OF ASSISTANCE.—

4               “(1) PREMIUM ASSISTANCE.—

5                       “(A) IN GENERAL.—The State issuing a  
6                       premium assistance certificate shall, upon ten-  
7                       der to the State of such certificate by the car-  
8                       rier or group health plan providing qualifying  
9                       coverage, pay the carrier or plan the amount of  
10                      the certificate.

11                     “(B) TIMING OF PAYMENTS.—Payments  
12                     under this paragraph shall commence in the  
13                     first month during which the individual obtains  
14                     qualifying coverage and is determined under  
15                     section 2104 to be a premium assistance eligible  
16                     individual.

17                     “(C) TREATMENT OF SURPLUSES AND  
18                     DEFICITS.—

19                       “(i) DEFICIT.—If the premium for  
20                       coverage is greater than the amount of the  
21                       premium assistance for an individual, the  
22                       individual is responsible for payment of  
23                       any difference.

24                       “(ii) SURPLUS.—If the premium for  
25                       coverage is less than the amount of the

1 premium assistance for an individual, the  
2 difference shall not be paid to the individ-  
3 ual or the carrier or plan but shall revert  
4 to the Federal Government.

5 “(2) COST-SHARING ASSISTANCE.

6 “(A) IN GENERAL.—The State issuing a  
7 cost-sharing assistance certificate shall, upon  
8 presentation to the State of evidence of such  
9 certificate by the carrier or group health plan  
10 providing coverage and evidence of cost-sharing  
11 amounts otherwise incurred for which a reduc-  
12 tion in cost-sharing is available under the cer-  
13 tificate, pay the carrier or plan the amount of  
14 the reduction in cost-sharing in relation to  
15 standard coverage.

16 “(B) TIMING OF PAYMENTS.—Payments  
17 under this paragraph shall be provided at the  
18 time an individual has obtained qualified stand-  
19 ard health coverage, is determined under sec-  
20 tion 2104 to be a cost-sharing assistance eligi-  
21 ble individual, and has incurred health care ex-  
22 penses of the type for which a cost-sharing re-  
23 duction is available under subparagraph (A).

24 “(3) ADMINISTRATIVE ERRORS.—A State is fi-  
25 nancially responsible for premium or cost-sharing as-

1       sistance paid based on an eligibility determination  
2       error to the extent the State’s error rate for eligi-  
3       bility determinations exceeds a maximum permissible  
4       error rate to be specified by the Secretary.

5       **“SEC. 2104. ELIGIBILITY DETERMINATIONS.**

6       “(a) IN GENERAL.—The Secretary shall promulgate  
7       regulations specifying requirements for State subsidy pro-  
8       grams with respect to determining eligibility for premium  
9       and cost-sharing assistance, including requirements with  
10      respect to—

11               “(1) application procedures;

12               “(2) information verification procedures;

13               “(3) timeliness of eligibility determinations;

14               “(4) procedures for applicants to appeal adverse  
15      decisions; and

16               “(5) any other matters determined appropriate  
17      by the Secretary.

18       “(b) SPECIFICATIONS FOR REGULATIONS.—The reg-  
19      ulations promulgated by the Secretary under subsection  
20      (a) shall include the following requirements:

21               “(1) FREQUENCY OF APPLICATIONS.—A State  
22      program shall provide that an individual may file an  
23      application for assistance with an agency designated  
24      by the State at any time, in person.

1           “(2) APPLICATION FORM.—A State program  
2       shall provide for the use of an application form de-  
3       veloped by the Secretary under subsection (c)(2).

4           “(3) DISTRIBUTION OF APPLICATIONS.—A  
5       State program shall distribute applications for as-  
6       sistance widely, including to employers, health plan  
7       purchasing organizations, brokers for health cov-  
8       erage, and appropriate public agencies.

9           “(4) CONVENIENT LOCATION TO SUBMIT APPLI-  
10      CATIONS.—A State program shall provide convenient  
11      locations for premium and cost-sharing assistance el-  
12      igible individuals to apply for premium and cost-  
13      sharing assistance.

14          “(5) REQUIREMENT TO SUBMIT REVISED AP-  
15      PLICATION.—A State program shall, in accordance  
16      with regulations promulgated by the Secretary, re-  
17      quire individuals to submit revised applications dur-  
18      ing a year to reflect changes in estimated family in-  
19      comes, including changes in employment status of  
20      family members, and changes in eligibility status de-  
21      scribed in section 2002(c) during the year. The  
22      State shall revise the amount of any premium and  
23      cost-sharing assistance based on such a revised ap-  
24      plication.

1           “(6) AFDC APPLICANTS.—A State program  
2           shall include a procedure under which individuals  
3           applying for benefits under title IV shall have an op-  
4           portunity to apply for assistance under this part in  
5           connection with such application.

6           “(7) VERIFICATION.—A State program shall  
7           provide for verification of the information supplied  
8           in applications under this part. Such verification  
9           may include examining return information disclosed  
10          to the State for such purpose under section  
11          6103(l)(15) of the Internal Revenue Code of 1986.

12          “(c) ADMINISTRATION OF STATE PROGRAM.—

13               “(1) IN GENERAL.—The Secretary shall estab-  
14               lish standards for States operating programs under  
15               this part which ensure that such programs are oper-  
16               ated in a uniform manner with respect to application  
17               procedures, data standards, and such other adminis-  
18               trative activities as the Secretary determines to be  
19               necessary.

20               “(2) APPLICATION FORMS.—The Secretary  
21               shall develop an application form for assistance  
22               which shall—

23                       “(A) be simple in form and understandable  
24                       to the average individual;

1           “(B) require the provision of information  
2           necessary to make a determination as to wheth-  
3           er an individual is a premium or cost-sharing  
4           assistance eligible individual including a dec-  
5           laration of estimated family income by the indi-  
6           vidual; and

7           “(C) require attachment of such docu-  
8           mentation as deemed necessary by the Sec-  
9           retary in order to ensure eligibility for assist-  
10          ance.

11          “(3) OUTREACH ACTIVITIES.—A State operat-  
12          ing a program under this part shall conduct such  
13          outreach activities as the Secretary determines ap-  
14          propriate.

15          “(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM  
16          AND COST-SHARING ASSISTANCE.—A determination by a  
17          State that an individual is a premium or cost-sharing as-  
18          sistance eligible individual shall be effective for the cal-  
19          endar year for which such determination is made unless  
20          a revised application submitted under subsection (b)(5) in-  
21          dicates that an individual is no longer eligible for premium  
22          or cost-sharing assistance.

23          “(e) PENALTIES FOR MATERIAL MISREPRESENTA-  
24          TIONS.—

1           “(1) IN GENERAL.—Any individual who know-  
2           ingly makes a material misrepresentation of infor-  
3           mation in an application for assistance under this  
4           part shall be liable to the Federal Government for  
5           the amount any premium and cost-sharing assist-  
6           ance received by an individual on the basis of a mis-  
7           representation and interest on such amount at a  
8           rate specified by the Secretary, and shall, in addi-  
9           tion, be liable to the Federal Government for \$2,000  
10          or, if greater, 3 times the amount any premium and  
11          cost-sharing assistance provided on the basis of a  
12          misrepresentation.

13          “(2) COLLECTION OF PENALTY AMOUNTS.—A  
14          State which receives an application for assistance  
15          with respect to which a material misrepresentation  
16          has been made shall collect the penalty amount re-  
17          quired under paragraph (1) and submit 50 percent  
18          of such amount to the Secretary in a timely manner.

19      **“SEC. 2105. END-OF-YEAR RECONCILIATION FOR PREMIUM**  
20                              **ASSISTANCE.**

21          “(a) IN GENERAL.—

22                  “(1) REQUIREMENT TO FILE STATEMENT.—An  
23                  individual who received premium assistance under  
24                  this part from a State for any month in a calendar  
25                  year shall file with the State an income reconcili-

1       ation statement to verify the individual's family in-  
2       come for the year. Such a statement shall be filed  
3       at such time, and contain such information, as the  
4       State may specify in accordance with regulations  
5       promulgated by the Secretary.

6               “(2) NOTICE OF REQUIREMENT.—A State shall  
7       provide a written notice of the requirement under  
8       paragraph (1) at the end of the year to an individual  
9       who received assistance under this part from such  
10      State in any month during the year.

11      “(b) RECONCILIATION OF PREMIUM ASSISTANCE  
12      BASED ON ACTUAL INCOME.—

13              “(1) IN GENERAL.—Based on and using the in-  
14      come reported in the reconciliation statement filed  
15      under subsection (a) with respect to an individual,  
16      the State shall compute the amount of premium as-  
17      sistance that should have been provided under this  
18      part with respect to the individual for the year in-  
19      volved.

20              “(2) OVERPAYMENT OF ASSISTANCE.—If the  
21      total amount of the premium assistance provided  
22      was greater than the amount computed under para-  
23      graph (1), the excess amount shall be treated as an  
24      underpayment of a tax imposed by chapter 1 of the  
25      Internal Revenue Code of 1986.



1           “(3) UNDERPAYMENT OF ASSISTANCE.—If the  
2           total amount of the premium assistance provided  
3           was less than the amount computed under para-  
4           graph (1), the amount of the difference shall be  
5           treated as an overpayment of tax imposed by such  
6           chapter, or in the event the taxpayer involved is enti-  
7           tled to a refund of such a tax, subject to the provi-  
8           sions of section 6402(d) of such Code.

9           “(c) VERIFICATION.—Each State may use such infor-  
10          mation as it has available to verify income of individuals  
11          with applications filed under this part, including return  
12          information disclosed to the State for such purpose under  
13          section 6103(l)(15) of the Internal Revenue Code of 1986.

14          “(d) PENALTIES FOR FAILURE TO FILE.—In the  
15          case of an individual who is required to file a statement  
16          under this section in a year who fails to file such a state-  
17          ment by such date as the Secretary shall specify in regula-  
18          tions, the entire amount of the premium assistance pro-  
19          vided in such year shall be considered an excess amount  
20          under subsection (b)(2) and such individual shall not be  
21          eligible for premium assistance under this part until such  
22          statement is filed. A State, using rules established by the  
23          Secretary, shall waive the application of this subsection  
24          if the individual establishes, to the satisfaction of the State

1 under such rules, good cause for the failure to file the  
2 statement on a timely basis.

3 “(e) PENALTIES FOR FALSE INFORMATION.—Any in-  
4 dividual who provides false information in a statement  
5 filed under subsection (a) is subject to the same penalties  
6 as are provided under section 2104(e) for a misrepresenta-  
7 tion of material fact described in such section.

8 “(f) NO RECONCILIATION FOR COST-SHARING AS-  
9 SISTANCE.—No reconciliation statement is required under  
10 this section with respect to cost-sharing assistance.

11 **“SEC. 2106. PAYMENTS TO STATES.**

12 “(a) PAYMENTS FOR PREMIUM AND COST-SHARING  
13 ASSISTANCE.—Subject to subsection (b) and section 2141,  
14 the Secretary shall provide for payment to each State op-  
15 erating a State subsidy program in an amount equal to  
16 the sum of—

17 “(1) the amount expended by the State under  
18 the program for premium assistance on behalf of  
19 premium assistance eligible individuals, and

20 “(2) the amount expended by the State under  
21 the program for cost-sharing assistance on behalf of  
22 cost-sharing assistance eligible individuals.

23 “(b) NO PAYMENT FOR MAINTENANCE-OF-EFFORT  
24 EXPENDITURES OR ADMINISTRATION.—No payment shall  
25 be made under subsection (a)—

1           “(1) for any State maintenance-of-effort ex-  
2           penditures required under section 2107, or

3           “(2) for any expenditures relating to adminis-  
4           tration of a State subsidy program.

5 For payment to States for administrative expenditures for  
6 State subsidy programs, see section 2142.

7           “(c) FUNDING.—The amount paid to States under  
8 subsection (a) shall be paid by the Secretary, from the  
9 Health Care Assurance Trust Fund (established under  
10 section 2143), at such time and in such form as provided  
11 in regulations promulgated by the Secretary, based on the  
12 form and manner in which payments are made to States  
13 under section 1903.

14 **“SEC. 2107. REQUIREMENT OF STATE MAINTENANCE-OF-**  
15 **EFFORT EXPENDITURES.**

16           “(a) IN GENERAL.—Payment to a State under sec-  
17 tion 2106 for any quarter in a year is conditioned upon—

18           “(1) the State making expenditures under this  
19 part from non-Federal funds (consistent with sub-  
20 section (d)) for premium assistance on behalf of pre-  
21 mium assistance eligible individuals and for cost-  
22 sharing assistance on behalf of cost-sharing assist-  
23 ance eligible individuals equal to at least the assist-  
24 ance maintenance-of-effort amount computed under  
25 subsection (b) for the quarter, and

1           “(2) the State meeting the maintenance-of-  
2           effort requirement of section 2125(a)(1) for the  
3           quarter.

4           “(b)     ASSISTANCE     MAINTENANCE-OF-EFFORT  
5     AMOUNT.—

6           “(1) IN GENERAL.—The assistance mainte-  
7           nance-of-effort amount computed under this sub-  
8           section for a State for a quarter in a year is equal  
9           to  $\frac{1}{4}$  of the product of the Federal-to-State conver-  
10          sion factor (specified under paragraph (5)) and the  
11          following:

12                   “(A) 1998.—For 1998, the product of—

13                           “(i) the 1997 per capita core benefit  
14                           amount (described in paragraph (3)) for  
15                           the State, and

16                           “(ii) the average monthly number of  
17                           AFDC recipients and non-cash medicaid  
18                           beneficiaries (as defined in section  
19                           1931(a)(2)) in the State during 1997,  
20           increased by the assistance increase factor (as  
21           defined in paragraph (4)) for 1998.

22                   “(B) 1999 AND THEREAFTER.—For quar-  
23           ters in 1999 or any succeeding year, the  
24           amount computed under subparagraph (A) or  
25           this subparagraph for the State for the preced-

1           ing year increased by the assistance increase  
2           factor under paragraph (4) for the year.

3           “(2) ESTIMATIONS OF AND ADJUSTMENTS TO  
4       STATE TOTAL FUNDING AMOUNT.—The Secretary  
5       shall—

6                   “(A) establish a process for estimating the  
7           assistance maintenance-of-effort amount for  
8           each State under paragraph (1) at the begin-  
9           ning of each fiscal year and adjusting such  
10          amount during such fiscal year; and

11                   “(B) notifying each State of the esti-  
12          mations and adjustments referred to in sub-  
13          paragraph (A).

14           “(3) 1997 PER CAPITA CORE BENEFIT AMOUNT  
15       DEFINED.—For purposes of paragraph (1), the  
16       ‘1997 per capita core benefit amount’ for a State is  
17       equal to the base per capita core benefit Federal  
18       payment limit for AFDC recipients and non-cash  
19       medicaid beneficiaries (specified in section  
20       1931(c)(2)(A)) multiplied (for each of years 1995,  
21       1996, and 1997) by a factor equal to 1 plus the  
22       FEHBP State rolling increase percentage (as de-  
23       fined in subsection (c)(2)) for the respective year.

24           “(4) ASSISTANCE INCREASE FACTOR DE-  
25       SCRIBED.—For purposes of paragraph (1)(A), the

1       ‘assistance increase factor’ for a year for a State is  
2       equal to the sum of—

3               “(A) the FEHBP State rolling increase  
4               factor (described in subsection (c)(2)) for the  
5               year,

6               “(B) the annual percentage change (which  
7               may be positive or negative) in the population  
8               of the State (as estimated by the Secretary),  
9               and

10              “(C)(i) 1 percentage point for 1998,

11              “(ii)  $\frac{2}{3}$  percentage point for 1999,

12              “(iii)  $\frac{1}{3}$  percentage point for 2000, and

13              “(iv) 0 percentage points for each subse-  
14              quent year.

15              “(5) FEDERAL-TO-STATE CONVERSION FAC-  
16       TOR.—For purposes of this title, the ‘Federal-to-  
17       State conversion factor’ for a State is equal to the  
18       ratio of—

19              “(A) 1 minus the Federal medical assist-  
20              ance percentage (as defined in section 1905(b))  
21              for the State for 1994, to

22              “(B) such Federal medical assistance per-  
23              centage.

24              “(c) FEHBP NATIONAL AND STATE ROLLING IN-  
25       CREASE PERCENTAGES.—

1           “(1) NATIONAL INCREASE PERCENTAGE.—For  
2           purposes of this title, the term ‘FEHBP national  
3           rolling increase percentage’ means, for a year, the 5-  
4           year weighted average of the annual national per-  
5           centage increase in the premiums for health plans  
6           offered under the Federal Employees Health Bene-  
7           fits Program (under chapter 89 of title 5, United  
8           States Code) for the 5-year period ending with the  
9           previous year.

10           “(2) STATE INCREASE PERCENTAGE.—For pur-  
11           poses of this title, the term ‘FEHBP State rolling  
12           increase percentage’ means, for a year with respect  
13           to a State, the 5-year weighted average of the an-  
14           nual percentage increase in the premiums for health  
15           plans offered in the State under the Federal Em-  
16           ployees Health Benefits Program (under chapter 89  
17           of title 5, United States Code) for the 5-year period  
18           ending with the previous year.

19           “(3) DETERMINATION.—The increase percent-  
20           ages under paragraphs (1) and (2) shall be deter-  
21           mined by the Secretary, in consultation with the Di-  
22           rector of Office of Personnel Management, based on  
23           the best information available. Such increases shall  
24           be adjusted—

“(A) to take into account the age distribution in the Federal workforce (not taking into account individuals 65 years of age or older, employees of the United States Postal Service, retirees, and annuitants) relative to the age distribution in the population of AFDC recipients and non-cash medicaid beneficiaries, and

“(B) to disregard any changes due to changes in the benefit package under the Federal Employees Health Benefits Program after 1994.

“(d) USE OF STATE FUNDS.—Each State subsidy program shall provide assurances satisfactory to the Secretary that Federal funds will not be used, directly or indirectly, to provide for the State expenditures required under this section.

“PART C—FINANCING FAILSAFE MECHANISM AND  
GENERAL PROVISIONS

“SEC. 2141. ENSURING DEFICIT NEUTRAL SPENDING ON  
PREMIUM AND COST-SHARING ASSISTANCE  
AND SUPPLEMENTAL ACUTE CARE BENEFITS.

“(a) LIMITATION ON FEDERAL EXPENDITURES.—

“(1) IN GENERAL.—In each fiscal year (beginning with 1998), Federal payments under this title shall be limited to the amount by which—



1           “(A) the aggregate limitation described in  
2           subsection (b) for the year, exceeds

3           “(B) the amount of the mandatory Federal  
4           expenditures under title XVIII and XIX for the  
5           year, including any offsetting receipts required  
6           under title XVIII but excluding any discre-  
7           tionary expenditures under such title or title  
8           XIX.

9           “(2) CONTINGENCY.—Any direct payment au-  
10          thority provided under part A or B with respect to  
11          premium and cost-sharing assistance or supple-  
12          mental acute care benefits is subject to the operation  
13          of this section.

14          “(b) AGGREGATE LIMITATION.—For purposes of this  
15          section, subject to subsection (d), the aggregate limitation  
16          described in this subsection—

17               “(1) for fiscal year 1998, is \$351 billion;

18               “(2) for fiscal year 1999, is \$392 billion;

19               “(3) for fiscal year 2000, is \$433 billion;

20               “(4) for fiscal year 2001, is \$482 billion;

21               “(5) for fiscal year 2002, is \$535 billion;

22               “(6) for fiscal year 2003, is \$594 billion;

23               “(7) for fiscal year 2004, is \$660 billion; and

24               “(8) for each succeeding fiscal year is the ag-  
25          gregate limitation under this subsection for the pre-

1       ceding fiscal year increased by the same percentage  
2       as the percentage growth in national health expendi-  
3       tures (as estimated by the Secretary) from the sec-  
4       ond preceding fiscal year to the preceding fiscal  
5       year.

6       “(c) MID-SESSION BUDGET REVIEW ESTIMATES.—  
7       As part the President’s supplemental summary providing  
8       revised estimates of the budget (commonly called the ‘mid-  
9       session review of the budget’) for each fiscal year (begin-  
10      ning with fiscal year 1997), the President shall issue the  
11      following:

12           “(1) ESTIMATE FOR UPCOMING YEAR.—An esti-  
13           mate of expenditures under titles XVIII and XIX  
14           and parts A and B of this title for the upcoming fis-  
15           cal year (determined without regard to this section).

16           “(2) INFORMATION ON ACTUAL EXPENDITURES  
17           FOR PRECEDING YEAR.—Information on actual ex-  
18           penditures under titles XVIII and XIX and parts A  
19           and B of this title for the preceding fiscal year de-  
20           termined taking into account adjustments under this  
21           section. Such information shall first be provide in  
22           the mid-session review for the fiscal year 1999  
23           budget.

24           “(3) INFORMATIONAL ESTIMATE FOR CURRENT  
25           YEAR.—An estimate of expenditures under titles

1 XVIII and XIX and parts A and B of this title for  
2 the current fiscal year. Such information shall first  
3 be provided in the mid-session review for the fiscal  
4 year 1998 budget.

5 “(d) RETROSPECTIVE ADJUSTMENT.—If the infor-  
6 mation provided under subsection (c)(2) during a fiscal  
7 year indicates (taking into account any adjustment under  
8 this section) that the amount of mandatory expenditures  
9 described in subsection (a)(1)(B) for the preceding fiscal  
10 year exceeded the aggregate limitation described in sub-  
11 section (b) for the year, for the succeeding fiscal year the  
12 aggregate limitation under subsection (b) shall be de-  
13 creased by the amount of such excess.

14 “(e) PROSPECTIVE ADJUSTMENT.—

15 “(1) IN GENERAL.—If the estimate provided  
16 under subsection (c)(1) during a fiscal year indicates  
17 that the amount of mandatory expenditures de-  
18 scribed in subsection (a)(1)(B) for the upcoming fis-  
19 cal year will exceed the aggregate limitation de-  
20 scribed in subsection (b) for the year, then for the  
21 succeeding fiscal year, the Director of the Office of  
22 Management and Budget, after consultation with the  
23 Secretary—

1           “(A) shall apply the adjustments described  
2           in paragraph (2) to the extent necessary to  
3           eliminate such excess, and

4           “(B) if such adjustments are insufficient  
5           to eliminate such excess, shall apply the adjust-  
6           ments described in paragraph (3).

7           “(2) REDUCTIONS IN AMOUNTS AVAILABLE FOR  
8           SUPPLEMENTAL ACUTE CARE BENEFITS PRO-  
9           GRAMS.—

10           “(A) IN GENERAL.—An adjustment under  
11           this paragraph consists of reduction in the limi-  
12           tations on payments to States established under  
13           section 2124(b).

14           “(B) MANNER OF REDUCTION.—Such re-  
15           duction shall be made in a proportional manner  
16           and shall provide for an aggregate reduction in  
17           the limits equal to the amount of such the re-  
18           duction required to comply with the require-  
19           ment of subsection (a).

20           “(3) REDUCTION IN PREMIUM ASSISTANCE  
21           AMOUNT.—

22           “(A) IN GENERAL.—An adjustment under  
23           this paragraph consists of uniform proportional  
24           reduction in the premium assistance percentage  
25           applied under section 2103(b)(3), but only with

1           respect to individuals who are not cost-sharing  
2           assistance eligible individuals.

3           “(B) MANNER OF REDUCTION.—The pro-  
4           portion of the uniform proportional reduction  
5           shall be calculated by the Director, in consulta-  
6           tion with the Secretary, in a manner that re-  
7           sults in an aggregate reduction in the payments  
8           to States under part A in an amount that  
9           assures (taking into account reductions result-  
10          ing from the adjustment under paragraph (2))  
11          compliance with the requirement of subsection  
12          (a).

13          “(4) NOTICE TO CONGRESS.—Before effecting  
14          any adjustment under this subsection, the Director  
15          shall submit to Congress a report that describes the  
16          adjustment to be made and the basis for making the  
17          adjustment.

18          “(5) NO AFFECT ON STATE MAINTENANCE-OF-  
19          EFFORT REQUIREMENTS.—Any adjustment under  
20          this subsection shall not affect the requirements for  
21          States under sections 2107 or 2125.

22          “(f) PRESIDENT’S BUDGET TO INCLUDE PREMIUM  
23          ASSISTANCE ESTIMATES.—

1           “(1) IN GENERAL.—When the President sub-  
2       mits a budget (as required by section 1105 of title  
3       31), the President shall include in such budget—

4           “(A) estimates of Federal expenditures  
5       under titles XVIII and XIX and parts A and B  
6       of this title otherwise provided without regard  
7       to this section; and

8           “(B) a comparison of the Federal expendi-  
9       tures under titles XVIII and XIX with the ag-  
10      gregate limitation established under subsection  
11      (b); and

12          “(C) estimates of adjustments under sub-  
13      section (d) that are necessary to comply with  
14      enforcement of the limitation under subsection  
15      (a).

16          “(2) FISCAL YEARS COVERED.—The President  
17      shall submit such estimates for the upcoming fiscal  
18      year and the following 4 fiscal years beginning with  
19      the budget submitted for fiscal year 1997, and

20          “(A) beginning with the budget for fiscal  
21      year 1998, the current fiscal year; and

22          “(B) beginning with the budget for fiscal  
23      year 1999, the current fiscal year and the pre-  
24      ceding fiscal year.

25          “(g) CBO INFORMATION AND ANALYSES.—

1           “(1) CBO TECHNICAL CORRECTIONS RE-  
2       PORT.—In or about January of each year when the  
3       Congressional Budget Office changes the economic  
4       and technical assumptions in the budget baseline  
5       used by such Office, the Director of such Office shall  
6       submit to the Congress a report on such changes.  
7       The report shall include an explanation of what the  
8       aggregate limitation amounts under subsection (b)  
9       might have been if they had been computed based on  
10      such changed assumptions.

11          “(2) CBO ANALYSIS.—In or about March of  
12      each year, after having an opportunity to analyze  
13      the report submitted under subsection (e)(1), the Di-  
14      rector of the Congressional Budget Office shall sub-  
15      mit to Congress a report that contains an analysis  
16      of the differences between the estimates contained in  
17      the President’s report and the estimates of such Of-  
18      fice based on the economic and technical assump-  
19      tions referred to in paragraph (1).

20   **“SEC. 2142. PAYMENTS FOR ADMINISTRATIVE EXPENSES**  
21                   **UNDER TITLE.**

22          “(a) IN GENERAL.—Subject to subsection (b), the  
23      Secretary shall pay to each State operating a State pro-  
24      gram under this part or part B, for each quarter begin-  
25      ning with the quarter commencing January 1, 1998, an

1 amount equal to 50 percent of the amounts expended dur-  
2 ing the quarter as found necessary by the Secretary for  
3 the proper and efficient administration of such programs  
4 in the State, not including any State maintenance-of-effort  
5 expenditures required under section 2107 or 2125.

6 “(b) LIMITATION.—

7 “(1) IN GENERAL.—The amount of funds which  
8 the Secretary is otherwise obligated to pay a State  
9 for quarters in a year under subsection (a) shall not  
10 exceed such proportion of the amount specified in  
11 paragraph (2) as the Secretary determines, taking  
12 into account relevant factors including the propor-  
13 tion of premium assistance eligible individuals (in-  
14 cluding cost-sharing assistance eligible individuals)  
15 who reside in the State, the relative costs of admin-  
16 istrative services in the State (compared to the na-  
17 tional average costs of administrative services), and  
18 total non-administrative expenditures by the State  
19 under this title.

20 “(2) TOTAL AVAILABLE ADMINISTRATIVE  
21 AMOUNT.—For purposes of this subsection, the  
22 amount specified in this paragraph for all calendar  
23 quarters in a year for payments to States shall not  
24 exceed—

25 “(A) \$2.3 billion for 1998,



1 “(B) \$2.5 billion for 1999,

2 “(C) \$2.7 billion for 2000,

3 “(D) \$2.9 billion for 2001,

4 “(E) \$3.1 billion for 2002,

5 “(F) \$3.3 billion for 2003, and

6 “(G) \$3.6 billion for 2004.

7 **“SEC. 2143. HEALTH CARE ASSURANCE TRUST FUND.**

8 “(a) CREATION OF TRUST FUND.—There is estab-  
9 lished in the Treasury of the United States a trust fund  
10 to be known as the ‘Health Care Assurance Trust Fund’  
11 (in this section referred to as the ‘Trust Fund’), consisting  
12 of such amounts as may be appropriated or credited to  
13 it under this section.

14 “(b) TRANSFERS TO THE TRUST FUND.—

15 “(1) IN GENERAL.—There are hereby appro-  
16 priated to the Trust Fund the amount determined  
17 by the Secretary of the Treasury, after consultation  
18 with the Secretary of Health and Human Services,  
19 to be equal to the sum of—

20 “(A) the decrease in Federal expenditures  
21 resulting from the provisions of, and the  
22 amendments made by, the Bipartisan Health  
23 Care Reform Act of 1994, and

1           “(B) amounts received by the Secretary  
2           pursuant to sections 2104(e), 2105(b)(2), and  
3           2105(e).

4           “(2) TRANSFERS FROM OTHER TRUST  
5           FUNDS.—The Secretary of Health and Human Serv-  
6           ices shall transfer each fiscal year to the Trust Fund  
7           from the Federal Hospital Insurance Trust Fund  
8           and the Federal Supplementary Medical Insurance  
9           Trust Fund the amount which the Secretary esti-  
10          mates is equal to the decrease in expenditures in  
11          each such trust fund attributable to the provisions  
12          of the Bipartisan Health Care Reform Act of 1994.

13          “(3) TRANSFERS FROM GIFTS AND BE-  
14          QUESTS.—The Secretary of Health and Human  
15          Services shall transfer each fiscal year to the Trust  
16          Fund any money gifts or bequests made to or on be-  
17          half of the United States for allocation to the Trust  
18          Fund.

19          “(c) EXPENDITURES.—Amounts in the Trust Fund  
20          shall be used as follows:

21               “(1) Amounts shall be appropriated to the Sec-  
22               retary for payments to States in a fiscal year for the  
23               programs under parts A and B of this title (and to  
24               the extent any such amount is not expended during

1 any fiscal year, such amount shall be available for  
2 such purpose for subsequent fiscal years).

3 “(2) Amounts shall be transferred to an ac-  
4 count in the General Fund of the Treasury in an  
5 amount equal to the estimate of the Secretary of the  
6 Treasury of the reductions in revenues deposited in  
7 the General Fund resulting from the amendments  
8 made to the Internal Revenue Code of 1986 by the  
9 Bipartisan Health Care Reform Act of 1994.

10 “(d) NATURE OF PAYMENT OBLIGATION.—Subject  
11 to section 2141, sections 2106, 2124, and 2142 constitute  
12 budget authority in advance of appropriations Acts, and  
13 represent the obligation of the Federal Government to pro-  
14 vide payments to States under such sections in accordance  
15 with the applicable provisions of this title.

16 **“SEC. 2144. LIMITATION ON USE OF FUNDS FOR ABOR-**  
17 **TIONS.**

18 “None of the funds appropriated to carry out this  
19 title shall be expended for premium assistance under this  
20 part that provides coverage of any abortion, for cost-shar-  
21 ing assistance under this part with respect to expenses in-  
22 curred for any abortion, or for supplemental acute care  
23 benefits under part B for any abortion, except in the case  
24 of an abortion where the procedure is necessary to save

1 the life of the mother or where the pregnancy is the result  
2 of an act of rape or incest.

3 **“SEC. 2145. AUDITS.**

4 “The Secretary shall conduct regular audits of the  
5 activities under the State programs conducted under this  
6 title.

7 **“SEC. 2146. DEMONSTRATION PROJECT AUTHORITY.**

8 “(a) IN GENERAL.—In the case of any experimental,  
9 pilot, or demonstration project which in the judgment of  
10 the Secretary is likely to assist in promoting the objectives  
11 of this title in a State or States, the Secretary may waive  
12 compliance with any of the requirements of this title to  
13 the extent and for the period the Secretary finds necessary  
14 to enable the Secretary to carry out the project.

15 “(b) RESTRICTION.—

16 “(1) FINDINGS.—The Secretary may authorize  
17 a waiver under subsection (a) only if the Secretary  
18 determines that under the waiver—

19 “(A) all individuals who would be premium  
20 assistance eligible individuals remain eligible for  
21 premium assistance,

22 “(B) benefits under part A are not reduced  
23 below the level of benefits otherwise provided,  
24 and

1           “(C) the amount of payments made by the  
2           Federal Government do not exceed the amount  
3           of payments otherwise provided.

4           “(2) LIMITATION.—The Secretary may not au-  
5           thorize a waiver of sections 2107 or 2125 (relating  
6           to State maintenance-of-effort).

7   **“SEC. 2147. DEFINITIONS AND DETERMINATIONS OF IN-**  
8           **COME.**

9           “For purposes of this title:

10          “(1) DETERMINATIONS OF INCOME.—

11               “(A) FAMILY INCOME.—The term ‘family  
12               income’ means, with respect to an individual  
13               who—

14                       “(i) is not a dependent (as defined in  
15                       subparagraph (B)) of another individual,  
16                       the sum of the modified adjusted gross in-  
17                       comes (as defined in subparagraph (D))  
18                       for the individual, the individual’s spouse,  
19                       and dependents of the individual; or

20                       “(ii) is a dependent of another indi-  
21                       vidual, the sum of the modified adjusted  
22                       gross incomes for the other individual, the  
23                       other individual’s spouse, and dependents  
24                       of the other individual.

1           “(B) DEPENDENT.—The term ‘dependent’  
2           shall have the meaning given such term under  
3           paragraphs (1) or (2) of section 152(a) of the  
4           Internal Revenue Code of 1986.

5           “(C) SPECIAL RULE FOR FOSTER CHIL-  
6           DREN.—For purposes of subparagraph (A), a  
7           child who is placed in foster care by a State  
8           agency shall not be considered a dependent of  
9           another individual.

10          “(D) MODIFIED ADJUSTED GROSS IN-  
11          COME.—The term ‘modified adjusted gross in-  
12          come’ means adjusted gross income (as defined  
13          in section 62(a) of the Internal Revenue Code  
14          of 1986)—

15               “(i) determined without regard to sec-  
16               tions 135, 162(l), 220, 911, 931, and 933  
17               of such Code, and

18               “(ii) increased by—

19                       “(I) the amount of interest re-  
20                       ceived or accrued by the individual  
21                       during the taxable year which is ex-  
22                       empt from tax,

23                       “(II) the amount of the social se-  
24                       curity benefits (as defined in section  
25                       86(d) of such Code) received during

1 the taxable year to the extent not in-  
2 cluded in gross income under section  
3 86 of such Code,

4 “(III) the amount of aid to fami-  
5 lies with dependent children received  
6 during the taxable year under part A  
7 of title IV to the extent not included  
8 in gross income under such Code, and

9 “(IV) the amount of any supple-  
10 mental security income benefits pro-  
11 vided under title XVI.

12 The determination under the preceding sen-  
13 tence shall be made without regard to any car-  
14 ryover or carryback.

15 “(E) ELECTION WITH RESPECT TO IN-  
16 COME DETERMINATION.—As elected by a family  
17 at the time of submission of an application for  
18 a premium or cost-sharing assistance under this  
19 part, family income shall be determined  
20 either—

21 “(i) by multiplying by a factor of 4  
22 the individual’s family income for the 3-  
23 month period immediately preceding the  
24 month in which the application is made, or

1                   “(ii) based upon estimated income for  
2                   the entire year in which the application is  
3                   submitted.

4                   “(2) APPLICABLE POVERTY LINE.—The term  
5                   ‘applicable poverty line’ means the income official  
6                   poverty line (as defined by the Office of Manage-  
7                   ment and Budget, and revised annually in accord-  
8                   ance with section 673(2) of the Omnibus Budget  
9                   Reconciliation Act of 1981) that—

10                   “(A) in the case of a family of less than  
11                   five individuals, is applicable to a family of the  
12                   size involved; and

13                   “(B) in the case of a family of more than  
14                   four individuals, is applicable to a family of  
15                   four persons.

16                   “(3) PREGNANT WOMAN.—The term ‘pregnant  
17                   woman’ includes a woman during the 60-day period  
18                   beginning on the last day of the pregnancy.

19                   “(4) PREMIUM.—Any reference to the term  
20                   ‘premium’ includes a reference to premium equiva-  
21                   lence for self-insured plans.”.



1 **SEC. 2102. OPERATION OF PROGRAM AS STATE PLAN RE-**  
2 **QUIREMENT UNDER MEDICAID.**

3 (a) IN GENERAL.—Section 1902(a) of the Social Se-  
4 curity Act (42 U.S.C. 1396a(a)), as amended by sections  
5 3303(a)(1), 3003(a), and 3201(f)(5), is amended—

6 (1) by striking “and” at the end of paragraph  
7 (63);

8 (2) by striking the period at the end of para-  
9 graph (64) and inserting “; and”; and

10 (3) by inserting after paragraph (64) the fol-  
11 lowing new paragraph:

12 “(65) provide for a State program furnishing  
13 premium subsidies for low-income individuals in ac-  
14 cordance with part A of title XXI.”.

15 (b) EFFECTIVE DATE.—The requirement of section  
16 1902(a)(65) of the Social Security Act (as added by sub-  
17 section (a)) shall apply to Federal financial participation  
18 for calendar quarters beginning on or after January 1,  
19 1998.

20 **SEC. 2103. APPLICATION OF MISCELLANEOUS PROVISIONS.**

21 (a) APPLICATION OF SAVE PROVISIONS.—Section  
22 1137(b) of the Social Security Act (42 U.S.C. 1320b-  
23 7(b)) is amended—

24 (1) by striking “and” at the end of paragraph  
25 (4),

1           (2) by striking the period at the end of para-  
2 graph (5) and inserting “; and”, and

3           (3) by adding at the end the following:

4           “(6) a State subsidy program under part A of  
5 title XXI.”.

6           (b) DISCLOSURE OF CERTAIN INFORMATION.

7           (1) IN GENERAL.—Subsection (l) of section  
8 6103 of the Internal Revenue Code of 1986 is  
9 amended by adding at the end the following new  
10 paragraph:

11           “(15) DISCLOSURE OF RETURN INFORMATION  
12 TO CARRY OUT HEALTH PREMIUM ASSISTANCE CER-  
13 TIFICATE PROGRAM.—The Secretary shall, upon  
14 written request from a State, disclose to officials of  
15 the State return information for purposes of deter-  
16 mining or verifying whether any individual is enti-  
17 tled to a premium assistance certificate under part  
18 A of title XXI of the Social Security Act and the  
19 amount thereof. Return information disclosed under  
20 this paragraph may be used by such officers and em-  
21 ployees only for the purposes of, and to the extent  
22 necessary in, making such determination or verifica-  
23 tion.”.

24           (2) CONFORMING CHANGE.—Paragraph (4) of  
25 section 6103(p) of such Code is amended by striking

1 “or (14)” each place it appears and inserting “(14)  
 2 or (15)”.

3 (c) APPLICATION OF DEFINITION OF STATE.—Sec-  
 4 tion 1001(a)(1) of the Social Security Act (42 U.S.C.  
 5 1301(a)(1)) is amended by striking “title XX” and insert-  
 6 ing “titles XX and XXI”.

## 7 **TITLE III—MEDICAID REFORMS**

### TABLE OF CONTENTS OF TITLE

#### **Subtitle A—Treatment of Acute Care Benefits for AFDC and Non-cash Beneficiaries**

Sec. 3001. Division of medicaid benefits into core benefits and supplemental benefits for AFDC and non-cash beneficiaries; limitation on Federal financial participation for core benefits; sunset in medical assistance.

Sec. 3002. Continuation of State medicaid eligibility categories.

#### **Subtitle B—Flexibility in Expenditures for Supplemental Benefits for AFDC and Non-cash Beneficiaries**

Sec. 3101. Provision of supplemental acute care benefits through State supplemental acute care benefit programs.

#### **“PART B—STATE SUPPLEMENTAL ACUTE CARE BENEFITS PROGRAMS**

“Sec. 2121. Establishment of State supplemental acute care benefits programs.

“Sec. 2122. Eligibility.

“Sec. 2123. Scope and provision of benefits; benefits administration.

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#### **Subtitle C—Increased State Flexibility in Contracting for Coordinated Care**

Sec. 3201. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services.

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Sec. 3301. Reduction in amount of payment adjustments for disproportionate share hospitals.

Sec. 3302. Elimination of medically needy program for individuals not in an institution.

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1 **Subtitle A—Treatment of Acute**  
2 **Care Benefits for AFDC and**  
3 **Non-cash Beneficiaries**

4 **SEC. 3001. DIVISION OF MEDICAID BENEFITS INTO CORE**  
5 **BENEFITS AND SUPPLEMENTAL BENEFITS**  
6 **FOR AFDC AND NON-CASH BENEFICIARIES;**  
7 **LIMITATION ON FEDERAL FINANCIAL PAR-**  
8 **TICIPATION FOR CORE BENEFITS; SUNSET IN**  
9 **MEDICAL ASSISTANCE.**

10 (a) IN GENERAL.—Title XIX of the Social Security  
11 Act is amended by redesignating section 1931 as section  
12 1932 and by inserting after section 1930 the following new  
13 section:

14 “MEDICAID REFORM RULES FOR BENEFITS FOR ACUTE  
15 MEDICAL SERVICES FOR AFDC RECIPIENTS AND  
16 NON-CASH MEDICAID BENEFICIARIES

17 “SEC. 1931. (a) APPLICATION OF SECTION.—

18 “(1) IN GENERAL.—This section applies with  
19 respect to medical assistance for acute medical serv-  
20 ices (as defined in paragraph (2)) under State plans  
21 under this title for calendar quarters beginning on  
22 or after January 1, 1995, provided to AFDC recipi-  
23 ents and non-cash medicaid categorical beneficiaries.

24 To the extent this section applies, it supersedes any

1       contrary provision of this title or of other applicable  
2       law.

3       “(2) DEFINITIONS.—In this section:

4               “(A) ACUTE MEDICAL SERVICES.—The  
5       term ‘acute medical services’ means items and  
6       services described in section 1905(a) other than  
7       the following:

8               “(i) Nursing facility services (as de-  
9       fined in section 1905(f)).

10              “(ii) Intermediate care facility for the  
11       mentally retarded services (as defined in  
12       section 1905(d)).

13              “(iii) Personal care services (as de-  
14       scribed in section 1905(a)(24)).

15              “(iv) Private duty nursing services (as  
16       referred to in section 1905(a)(8)).

17              “(v) Home or community-based serv-  
18       ices furnished under a waiver granted  
19       under subsection (c), (d), or (e) of section  
20       1915.

21              “(vi) Home and community care fur-  
22       nished to functionally disabled elderly indi-  
23       viduals under section 1929.

24              “(vii) Community supported living ar-  
25       rangements services under section 1930.

1           “(viii) Case-management services (as  
2           described in section 1915(g)(2)).

3           “(ix) Home health care services (as  
4           referred to in section 1905(a)(7)), clinic  
5           services, and rehabilitation services that  
6           are furnished to an individual who has a  
7           condition or disability that qualifies the in-  
8           dividual to receive any of the services de-  
9           scribed in a previous clause.

10          “(x) Hospice care.

11          “(B) AFDC RECIPIENT.—The term  
12          ‘AFDC recipient’ means, for a month, an indi-  
13          vidual who is receiving aid or assistance under  
14          any plan of the State approved under title I, X,  
15          XIV, or XVI, or part A or part E of title IV  
16          for the month.

17          “(C) CORE BENEFITS.—The term ‘core  
18          benefits’ means benefits with respect to acute  
19          medical services which the Secretary identifies  
20          under subsection (b)(1) as typically included in  
21          the services covered under benchmark coverage  
22          (as defined in section 1903(1) of the Bipartisan  
23          Health Care Reform Act of 1994).

24          “(D) NON-CASH MEDICAID BENE-  
25          FICIARY.—The term ‘non-cash medicaid bene-

1           ficiary’ means an individual described in section  
2           1902(a)(10)(A) who is not an AFDC recipient  
3           or an SSI recipient.

4           “(E) SSI RECIPIENT.—The term ‘SSI re-  
5           cipient’ means, for a month, an individual—

6                   “(i) with respect to whom supple-  
7                   mental security income benefits are being  
8                   paid under title XVI of the Social Security  
9                   Act for the month,

10                   “(ii) who is receiving a supplementary  
11                   payment under section 1616 of such Act or  
12                   under section 212 of Public Law 93–66 for  
13                   the month,

14                   “(iii) who is receiving monthly bene-  
15                   fits under section 1619(a) of the Social Se-  
16                   curity Act (whether or not pursuant to sec-  
17                   tion 1616(c)(3) of such Act) for the  
18                   month, or

19                   “(iv) who is treated under section  
20                   1619(b) of the Social Security Act as re-  
21                   ceiving supplemental security income bene-  
22                   fits in a month for purposes of title XIX  
23                   of such Act.

24           “(F) SUPPLEMENTAL ACUTE CARE BENE-  
25           FITS.—The term ‘supplemental acute care bene-

1           fits’ means benefits for acute medical services  
2           which are not—

3                   “(i) core benefits, and

4                   “(ii) benefits for items or services de-  
5                   scribed in clauses (i) through (x) of sub-  
6                   paragraph (A).

7           “(b) DIVISION OF ACUTE MEDICAL SERVICE BENE-  
8   FITS INTO CORE BENEFITS AND SUPPLEMENTAL ACUTE  
9   CARE BENEFITS.—The Secretary shall divide the class of  
10   benefits for acute medical services into the following bene-  
11   fit groups:

12                   “(1) CORE BENEFITS.—A group of benefits  
13           consisting of core benefits (as defined in subsection  
14           (a)(2)(C)).

15                   “(2) SUPPLEMENTAL ACUTE CARE BENE-  
16           FITS.—A group of benefits consisting of supple-  
17           mental acute care benefits (as defined in subsection  
18           (a)(2)(F)).

19           “(c) LIMITATION ON AMOUNT OF FEDERAL FINAN-  
20   CIAL PARTICIPATION FOR BENEFITS FOR ACUTE MEDI-  
21   CAL SERVICES FOR AFDC RECIPIENT AND NON-CASH  
22   MEDICAID BENEFICIARIES.—

23                   “(1) LIMITATION ON CORE BENEFITS FOR 1995  
24           THROUGH 1997.—With respect to expenditures for  
25           medical assistance for core benefits for AFDC re-



1        cipients and non-cash medicaid beneficiaries in a  
2        State the following rules shall apply:

3                “(A) 1995.—For all quarters in calendar  
4                year 1995, Federal financial participation under  
5                section 1903(a)(1) shall not be payable to the  
6                extent that per capita expenditures for such as-  
7                sistance exceed a per capita limiting amount  
8                equal to the base per capita core benefit Fed-  
9                eral payment limit for AFDC recipients and  
10              non-cash medicaid beneficiaries (specified in  
11              paragraph (2)(A)) increased by the FEHBP  
12              national rolling increase percentage (as defined  
13              in section 2107(c)(1)) for 1995.

14              “(B) 1996 AND 1997.—For all quarters in  
15              calendar year 1996 and for all quarters in cal-  
16              endar year 1997, Federal financial participation  
17              under section 1903(a)(1) shall not be payable  
18              to the extent that per capita expenditures for  
19              such assistance for such year exceed a per cap-  
20              ita limiting amount equal to the per capita lim-  
21              iting amount established under subparagraph  
22              (A) or this subparagraph, respectively, for the  
23              preceding year increased by the FEHBP na-  
24              tional rolling increase percentage (as defined in

1           section 2107(c)(1)) for 1996 or 1997, respec-  
2           tively.

3           “(C) ESTIMATIONS AND ADJUSTMENTS.—  
4           The Secretary shall—

5                 “(i) establish a process for estimating  
6                 the limiting amounts under this paragraph  
7                 at the beginning of each year and adjust-  
8                 ing such amount during such year; and

9                 “(ii) notifying each State of the esti-  
10                mations and adjustments referred to in  
11                clause (i).

12           “(2) BASE PER CAPITA CORE BENEFIT FED-  
13           ERAL PAYMENT LIMIT FOR AFDC RECIPIENTS AND  
14           NON-CASH MEDICAID BENEFICIARIES.—

15                 “(A) IN GENERAL.—In paragraph (1)(A),  
16                 the ‘base per capita core benefit Federal pay-  
17                 ment limit for AFDC recipients and non-cash  
18                 medicaid beneficiaries’ specified in this subpara-  
19                 graph, for a State, is—

20                 “(i) the baseline Federal medicaid  
21                 core benefit payments for AFDC recipients  
22                 and non-cash medicaid beneficiaries (as de-  
23                 fined in subparagraph (B)) for the State,  
24                 divided by

1           “(ii) the number of AFDC recipients  
2           and non-cash medicaid beneficiaries en-  
3           rolled in the State plan under this title in  
4           1994, as determined under subparagraph  
5           (C).

6           “(B) DETERMINATION OF BASELINE FED-  
7           ERAL MEDICAID CORE BENEFIT PAYMENTS FOR  
8           AFDC RECIPIENTS AND NON-CASH MEDICAID  
9           BENEFICIARIES.—For purposes of subpara-  
10          graph (A)(i), the ‘baseline medicaid core benefit  
11          expenditures for AFDC recipients and non-cash  
12          medicaid beneficiaries’ for a State is the  
13          amount of Federal payments made under sec-  
14          tion 1903(a)(1) with respect to medical assist-  
15          ance furnished for core benefits for AFDC re-  
16          cipients and non-cash medicaid beneficiaries for  
17          all calendar quarters in 1994.

18          “(C) DETERMINATION OF NUMBER OF  
19          AFDC RECIPIENTS AND NON-CASH MEDICAID  
20          BENEFICIARIES.—For purposes of subpara-  
21          graph (A)(ii), the number of AFDC recipients  
22          and non-cash medicaid beneficiaries for a State  
23          for 1994 shall be determined based on actual  
24          reports submitted by the State to the Secretary.  
25          In the case of individuals who were not recipi-

1           ents or beneficiaries for the entire fiscal year,  
2           the number shall take into account only the  
3           portion of the year in which they were such re-  
4           cipients. The Secretary may audit such reports.

5           “(3) LIMITATION ON BENEFITS FOR ACUTE  
6           MEDICAL SERVICES AFTER 1997.—With respect to  
7           expenditures for medical assistance for acute medical  
8           services benefits for AFDC recipients and non-cash  
9           medicaid beneficiaries in a State for quarters in a  
10          calendar year after 1997—

11                 “(A) no such Federal financial participa-  
12                 tion shall be payable under section 1903(a)(1),  
13                 and

14                 “(B) such a recipient or beneficiary is not  
15                 entitled to receive any medical assistance for  
16                 such benefits under the State plan under this  
17                 title.

18           “(4) ADDITIONAL RULES.—For purposes of this  
19          subsection—

20                 “(A) DISPROPORTIONATE SHARE PAY-  
21                 MENTS NOT INCLUDED.—Payments attributable  
22                 to section 1923 shall not be counted in the  
23                 amount of Federal payments.

24                 “(B) TREATMENT OF DISALLOWANCES.—  
25          The amount of Federal payments shall take

1           into account amounts (or an estimate of  
2           amounts) disallowed.

3           “(C) APPLICATION TO PARTICULAR ITEMS  
4           AND SERVICES.—In determining the Federal  
5           payment with respect to a category of items  
6           and services (within the core benefits) furnished  
7           in a State, there shall be counted only that pro-  
8           portion of such expenditures (determined only  
9           with respect to medical assistance furnished to  
10          AFDC recipients and non-cash medicaid bene-  
11          ficiaries) that were attributable to items and  
12          services included in the core benefits (taking  
13          into account any limitation on amount, dura-  
14          tion, or scope of items and services included in  
15          such benefits).

16          “(d) CONDITIONING FEDERAL FINANCIAL PARTICI-  
17          PATION ON STATE MAINTENANCE-OF-EFFORT.—

18               “(1) IN GENERAL.—Payment to a State under  
19          section 1903(a) for a quarter during 1995, 1996, or  
20          1997 is conditioned upon the State making expendi-  
21          tures under this title from non-Federal funds (con-  
22          sistent with paragraph (3)) for core benefits for  
23          AFDC recipients and non-cash medicaid bene-  
24          ficiaries equal to at least the State maintenance-of-

1 effort amount computed under paragraph (2) for the  
2 year.

3 “(2) STATE MAINTENANCE-OF-EFFORT  
4 AMOUNT.—The State maintenance-of-effort amount  
5 computed under this paragraph for a State for a  
6 year is equal to the product of—

7 “(A) the amount that would be computed  
8 as the per capita limiting amount under sub-  
9 section (c)(1) for the State for the year if the  
10 FEHBP State rolling increase percentage (as  
11 defined in section 2107(c)(2)) were substituted  
12 for any reference to the FEHBP national roll-  
13 ing increase percentage in such subsection; and

14 “(B) the Federal-to-State conversion factor  
15 (as defined in section 2107(b)(5)).

16 “(3) USE OF STATE FUNDS.—Each State shall  
17 provide assurances satisfactory to the Secretary that  
18 Federal funds will not be used, directly or indirectly,  
19 to provide for the State expenditures required under  
20 this subsection.”.

21 (b) CONFORMING AMENDMENT.—Section 1903(i) of  
22 the Social Security Act (42 U.S.C. 1396b(i)), as amended  
23 by section 3303(a)(3), is amended—

24 (1) by striking “or” at the end of paragraph  
25 (12),

1           (2) by striking the period at the end of para-  
2           graph (13) and inserting “; or”, and

3           (3) by inserting after paragraph (13) the  
4           following:

5           “(14) in accordance with section 1931, with re-  
6           spect to amounts expended for medical assistance—

7                   “(A) for supplemental acute care benefits  
8                   (as defined in section 1931(a)(2)(F)) for AFDC  
9                   recipients and non-cash medicaid beneficiaries  
10                  for calendar quarters beginning on or after  
11                  January 1, 1995,

12                   “(B) for core benefits (as defined in sec-  
13                   tion 1931(a)(2)(C)) for AFDC recipients and  
14                   non-cash medicaid beneficiaries for calendar  
15                   quarters beginning on or after January 1,  
16                   1995, and before January 1, 1998, to the ex-  
17                   tent they exceed limits specified in section  
18                   1931(c)(1), and

19                   “(C) for core benefits for AFDC recipients  
20                   and non-cash medicaid beneficiaries for cal-  
21                   endar quarters beginning on or after January  
22                   1, 1998.”.

1 **SEC. 3002. CONTINUATION OF STATE MEDICAID ELIGI-**  
2 **BILITY CATEGORIES.**

3 (a) IN GENERAL.—Section 1902(a) of the Social Se-  
4 curity Act (42 U.S.C. 1369a(a)), as amended by section  
5 3303(a)(1), is amended—

6 (1) by striking “and” at the end of paragraph  
7 (60);

8 (2) by striking the period at the end of para-  
9 graph (61) and inserting “; and ”; and

10 (3) by inserting after paragraph (61) the fol-  
11 lowing new paragraph:

12 “(62) provide for the continuation through De-  
13 cember 31, 1997, of eligibility for medical assistance  
14 under section 1902(a)(10)(A) of any class or cat-  
15 egory of individuals eligible for medical assistance  
16 under such section during fiscal year 1994.”.

17 (b) EFFECTIVE DATE.—The amendments made by  
18 subsection (a) shall apply to payments for calendar quar-  
19 ters beginning on or after January 1, 1995.



1 **Subtitle B—Flexibility in Expendi-**  
2 **tures for Supplemental Benefits**  
3 **for AFDC and Non-cash Bene-**  
4 **ficiaries**

5 **SEC. 3101. PROVISION OF SUPPLEMENTAL ACUTE CARE**  
6 **BENEFITS THROUGH STATE SUPPLEMENTAL**  
7 **ACUTE CARE BENEFIT PROGRAMS.**

8 (a) IN GENERAL.—Title XXI of the Social Security  
9 Act, as added by section 2101(a), is amended by inserting  
10 after part A the following new part:

11 “PART B—STATE SUPPLEMENTAL ACUTE CARE  
12 BENEFITS PROGRAMS  
13 “SEC. 2121. ESTABLISHMENT OF STATE SUPPLEMENTAL  
14 ACUTE CARE BENEFITS PROGRAMS.

15 “(a) IN GENERAL.—Each State shall establish a  
16 State supplemental acute care benefits program (each in  
17 this part referred to as a ‘State supplemental acute care  
18 benefits program’) that provides supplemental acute care  
19 benefits for supplemental benefit eligible individuals.

20 “(b) AVAILABILITY OF FUNDS.—Each State with a  
21 State supplemental acute care benefits program approved  
22 under this part is entitled, for calendar quarters beginning  
23 on or after January 1, 1995, to payment under section  
24 2124.

1       “(c) APPROVAL OF STATE PROGRAMS; PROGRAM DE-  
2       SCRIPTIONS.—The Secretary may not approve a State  
3       supplemental acute care benefits program unless the State  
4       has submitted a detailed description of the form and man-  
5       ner in which it will carry out the program (consistent with  
6       the applicable requirements of this part) and the Secretary  
7       finds that the program meets such applicable require-  
8       ments.

9       **“SEC. 2122. ELIGIBILITY.**

10       “(a) IN GENERAL.—In this part, the term ‘supple-  
11       mental benefit eligible individual’ means an individual  
12       who, as of the time of provision of supplemental acute care  
13       benefits, is described as follows:

14               “(1) 1995 THROUGH 1997.—The individual is  
15       an AFDC recipient or a non-cash medicaid bene-  
16       ficiary (as such terms are defined in section  
17       1931(a)(2)).

18               “(2) 1998 AND THEREAFTER.—The individual  
19       is a premium assistance eligible individual (as de-  
20       fined in section 2102(a)).

21       “(b) CONSTRUCTION.—Nothing in this part shall be  
22       construed to create an entitlement for any specific supple-  
23       mental benefit eligible individual.

1 **“SEC. 2123. SCOPE AND PROVISION OF BENEFITS; BENE-**  
2 **FITS ADMINISTRATION.**

3 “(a) IN GENERAL.—The supplemental acute care  
4 benefits that may be made available under a State supple-  
5 mental acute care benefits program may include supple-  
6 mental acute care benefits (as defined in section  
7 1931(a)(2)(F)).

8 “(b) COVERAGE OF BENEFITS.—Each State supple-  
9 mental acute care benefits program—

10 “(1) shall establish methods and standards to  
11 select the types, and the amount, duration, and  
12 scope, of supplemental acute care benefits included  
13 in the program and to assure access to, and the  
14 quality of, services included in such benefits;

15 “(2) in providing benefits for supplemental ben-  
16 efit eligible individuals—

17 “(A) may vary the supplemental acute care  
18 benefits provided among reasonable classes of  
19 such individuals, and

20 “(B) may take into account the individual  
21 needs of individuals; and

22 “(3) shall coordinate the provision of such bene-  
23 fits with other health insurance coverage and health  
24 benefit programs in a manner that avoids duplica-  
25 tion of benefits.

1       “(c) PAYMENT METHODS.—Benefits under a pro-  
2 gram may be made available in the form of direct provi-  
3 sion of services, reimbursement of providers, prepayment  
4 to providers or health plans on a capitation basis, reim-  
5 bursement of supplemental benefit eligible individuals for  
6 expenses incurred for supplemental acute care benefits, or  
7 a combination of these methods.

8       “(d) ADMINISTRATION.—

9               “(1) STATE AGENCY.—Each State supplemental  
10 acute care benefits program shall designate any ap-  
11 propriate State agency to administer the program.

12              “(2) COORDINATION.—The State supplemental  
13 acute care benefits program shall specify how the  
14 program—

15                   “(A) will be coordinated with the State  
16 medicaid plan, titles V and XX of the Social  
17 Security Act, part A of this title, and any other  
18 Federal or State programs that provide services  
19 or assistance targeted to supplemental benefit  
20 eligible individuals, and

21                   “(B) will be coordinated with qualified  
22 health coverage.

23       “(e) REPORTS AND INFORMATION TO SECRETARY;  
24 AUDITS.—Each State supplemental acute care benefits  
25 program shall furnish to the Secretary—

1           “(1) such reports, and cooperate with such au-  
2           dits, as the Secretary determines are needed con-  
3           cerning the State’s administration of the program  
4           under this part, including the processing of any  
5           claims under the program, and

6           “(2) such data and information as the Sec-  
7           retary may require in order to carry out the Sec-  
8           retary’s responsibilities.

9   **“SEC. 2124. PAYMENTS TO STATES.**

10       “(a) IN GENERAL.—

11           “(1) PAYMENTS FOR SUPPLEMENTAL ACUTE  
12           CARE BENEFITS.—Subject to paragraph (2), sub-  
13           section (b), and sections 2125 and 2141, the Sec-  
14           retary shall provide for payment to each State oper-  
15           ating an approved State supplemental acute care  
16           benefits program in an amount equal to the amount  
17           expended by the State under the program during the  
18           quarter for supplemental acute care benefits for sup-  
19           plemental benefit eligible individuals.

20           “(2) NO PAYMENT FOR MAINTENANCE-OF-EF-  
21           FORT EXPENDITURES OR ADMINISTRATION.—No  
22           payment shall be made under paragraph (1)—

23           “(A) for any State maintenance-of-effort  
24           expenditures required under section 2125, or

1           “(B) for any expenditures relating to ad-  
2           ministration of a State subsidy program.

3           “(3) PAYMENTS FOR RELATED ADMINISTRA-  
4           TIVE EXPENSES.—

5           “(A) 1995 THROUGH 1997.—

6           “(i) IN GENERAL.—Subject to sec-  
7           tions 2123(d)(2), 2124(b), 2125, and  
8           2141, and clause (ii), the Secretary shall  
9           pay to each State operating a State supple-  
10          mental acute care benefits program, for  
11          each quarter beginning with the quarter  
12          commencing January 1, 1995, and ending  
13          before January 1, 1998, an amount equal  
14          to 50 percent of the amounts expended  
15          during the quarter as found necessary by  
16          the Secretary for the proper and efficient  
17          administration of such program, not in-  
18          cluding any State maintenance-of-effort ex-  
19          penditures required under section 2125.

20          “(ii) LIMITATION.—The Secretary  
21          shall not find under clause (i) amounts ex-  
22          pended to be for the proper and efficient  
23          administration of a State supplemental  
24          acute care benefits program if such  
25          amounts exceed 3 percent of the total ex-

1           penditures under the program in the quar-  
2           ter (including State maintenance-of-effort  
3           expenditures under section 2125).

4           “(B) REFERENCE TO PAYMENT FOR AD-  
5           MINISTRATIVE EXPENSES AFTER 1997.—For  
6           payment for administrative expenses under this  
7           part after 1997, see section 2142.

8           “(4) FUNDING.—Payments to States under this  
9           subsection shall be made by the Secretary, from the  
10          Health Care Assurance Trust Fund (established  
11          under section 2143), at such time and in such form  
12          as provided in regulations promulgated by the Sec-  
13          retary, based on the form and manner in which pay-  
14          ments are made under section 1903.

15          “(b) LIMITATION ON PAYMENTS FOR SUPPLE-  
16          MENTAL ACUTE CARE BENEFITS.—

17               “(1) IN GENERAL.—Subject to section 2141  
18               and paragraphs (2) and (3), the total amount of  
19               payments that may be made to a State under sub-  
20               section (a)(1) for all quarters in a calendar year may  
21               not exceed the following:

22                       “(A) 1995.—For 1995, the product of—

23                               “(i) the initial per capita supple-  
24                               mental acute care benefit Federal payment

1 limit (described in subsection (c)) for the  
2 State, and

3 “(ii) the average monthly number of  
4 supplemental benefit eligible individuals in  
5 the State in 1995.

6 “(B) 1996 AND 1997.—For each of cal-  
7 endar years 1996 and 1997, the product of—

8 “(i) the limit specified in this clause  
9 (or subparagraph (A)(i)) for the State for  
10 the previous year increased by the FEHBP  
11 national rolling increase factor for the year  
12 (as defined in section 2107)(c)(1)), and

13 “(ii) the average monthly number of  
14 supplemental benefit eligible individuals in  
15 the State in the year.

16 “(C) 1998 AND THEREAFTER.—For 1998  
17 or any succeeding year, the amount computed  
18 under this subparagraph (or subparagraph (B))  
19 for the State for the preceding year increased  
20 by the supplemental acute care benefit increase  
21 factor under subsection (d) for the year.

22 “(2) ADJUSTMENT FOR AVAILABILITY OF ADDI-  
23 TIONAL FUNDS.—If the Secretary determines for a  
24 year that the total amount of the Federal payments  
25 under section 2124 for a year for all the States is



1 less than the sum of the limitations for the year for  
2 all the States established under paragraph (1), the  
3 limitation for each State under this subsection shall  
4 be increased in a pro-rata manner by such an  
5 amount as will not result in such total Federal pay-  
6 ments under section 2124 exceeding the sum of such  
7 limits for all the States for the year.

8 “(3) ESTIMATIONS AND ADJUSTMENTS.—The  
9 Secretary shall—

10 “(A) establish a process for estimating the  
11 limit established under this subsection for a  
12 year at the beginning of the year and adjusting  
13 such amount during such year; and

14 “(B) notifying each State of the esti-  
15 mations and adjustments referred to in sub-  
16 paragraph (A).

17 “(c) INITIAL PER CAPITA SUPPLEMENTAL ACUTE  
18 CARE BENEFIT FEDERAL PAYMENT LIMIT DEFINED.—

19 “(1) IN GENERAL.—For purposes of subsection  
20 (b)(1)(A), the ‘initial per capita supplemental acute  
21 care benefit Federal payment limit’ for a State for  
22 a year is equal to the base per capita supplemental  
23 acute care Federal payments (described in para-  
24 graph (2)) increased by the FEHBP national rolling

1       increase percentage (as defined in section  
2       2107(c)(1)) for 1995.

3           “(2) BASE PER CAPITA SUPPLEMENTAL ACUTE  
4       CARE FEDERAL PAYMENTS.—For purposes of para-  
5       graph (1), the ‘base per capita supplemental acute  
6       care Federal payments’ described in this paragraph,  
7       for a State, is—

8           “(A) the baseline Federal medicaid supple-  
9       mental acute care benefit expenditures (as de-  
10      fined in paragraph (3)) for the State, divided  
11      by

12          “(B) the number of AFDC recipients and  
13      non-cash medicaid beneficiaries (as described in  
14      section 1931(a)(2)) enrolled in the State plan  
15      under title XIX in 1994, as determined under  
16      paragraph (4) consistent with section  
17      1931(c)(3)(C).

18          “(3) DETERMINATION OF BASELINE FEDERAL  
19      MEDICAID SUPPLEMENTAL ACUTE CARE PAY-  
20      MENTS.—

21          “(A) IN GENERAL.—For purposes of para-  
22      graph (2)(A), the ‘baseline Federal medicaid  
23      supplemental acute care payments’ for a State  
24      is the amount of Federal payments made under  
25      section 1903(a)(1) with respect to medical as-

1           sistance furnished for supplemental acute care  
2           benefits (as defined in section 1931(b)(2)) for  
3           AFDC recipients and non-cash medicaid bene-  
4           ficiaries for all calendar quarters in 1994.

5           “(B) DISPROPORTIONATE SHARE PAY-  
6           MENTS NOT INCLUDED.—In applying subpara-  
7           graph (A), payments attributable to section  
8           1923 shall not be counted in the amount of  
9           payments.

10          “(C) TREATMENT OF DISALLOWANCES.—  
11          The amount determined under this paragraph  
12          shall take into account amounts (or an estimate  
13          of amounts) disallowed under title XIX.

14          “(4) APPLICATION TO PARTICULAR ITEMS AND  
15          SERVICES.—For purposes of this subsection, in de-  
16          termining the per capita supplemental medical bene-  
17          fit expenditure limit for a category of items and  
18          services (within the supplemental acute care bene-  
19          fits) furnished in a State, there shall be counted only  
20          that proportion of such expenditures (determined  
21          only with respect to medical assistance furnished to  
22          AFDC recipients and non-cash medicaid bene-  
23          ficiaries) that were attributable to items and services  
24          included in the supplemental acute care benefits  
25          (taking into account any limitation on amount, dura-

1       tion, or scope of items and services included in such  
2       benefits).

3       “(d) SUPPLEMENTAL ACUTE CARE BENEFIT IN-  
4       CREASE FACTOR DESCRIBED.—For purposes of sub-  
5       section (b)(1)(C), the ‘supplemental medical benefit in-  
6       crease factor’ for a year for a State is equal to the sum  
7       of—

8               “(1) the FEHBP national rolling increase fac-  
9       tor (as defined in section 2107(c)(1)) for the year,

10              “(2) the annual percentage change (which may  
11       be positive or negative) in the population of the  
12       State (as estimated by the Secretary for purposes of  
13       section 2107(c)(4)(B)), and

14              “(3)(A) 1 percentage point for 1998,

15              “(B)  $\frac{2}{3}$  percentage point for 1999,

16              “(C)  $\frac{1}{3}$  percentage point for 2000, and

17              “(D) 0 percentage points for each subsequent  
18       year.

19       **“SEC. 2125. STATE MAINTENANCE-OF-EFFORT REQUIRE-**  
20               **MENT.**

21       “(a) IN GENERAL.—Payment to a State under sec-  
22       tion 2124 for a quarter in a year (beginning with 1995)  
23       is conditioned upon—

24              “(1) the State making expenditures for supple-  
25       mental acute care benefits under this part from non-

1 Federal funds (consistent with subsection (d)) for  
2 supplemental benefit eligible individuals equal to at  
3 least the supplemental benefit maintenance-of-effort  
4 amount computed under subsection (b) for the quar-  
5 ter, and

6 “(2) for quarters beginning on or after January  
7 1, 1998, the State meeting the maintenance-of-effort  
8 requirement under section 2107(a)(1) for the quar-  
9 ter.

10 “(b) SUPPLEMENTAL BENEFITS MAINTENANCE-OF-  
11 EFFORT AMOUNT.—The supplemental benefits mainte-  
12 nance-of-effort amount computed under this subsection  
13 for a State for a quarter in a year is equal to  $\frac{1}{4}$  of the  
14 product of—

15 “(1) the amount that would be computed as the  
16 minimum limitation under section 2124(b) for the  
17 State for all quarters in the year (determined with-  
18 out regard to section 2124(b)(2)) if the FEHBP  
19 State rolling increase percentage (as defined in sec-  
20 tion 2107(b)(2)) were substituted for the FEHBP  
21 national rolling increase percentage in section  
22 2124(c)(1)(A) and in determining the supplemental  
23 medical benefit increase factor under 2124(d); and

24 “(2) the Federal-to-State conversion factor  
25 (specified under section 2107(b)(5)).

1       “(c) USE OF STATE FUNDS.—Each State supple-  
2 mental acute care benefits program shall provide assur-  
3 ances satisfactory to the Secretary that Federal funds will  
4 not be used, directly or indirectly, to provide for the State  
5 expenditures required under this section.”.

6       (b) CONFORMING AMENDMENT TO MEDICAID PRO-  
7 GRAM.—Section 1931 of the Social Security Act, as added  
8 by section 3001, is amended by adding at the end the fol-  
9 lowing:

10       “(e) ELIMINATION OF ENTITLEMENT FOR SUPPLE-  
11 MENTAL ACUTE CARE BENEFITS.—With respect to medi-  
12 cal assistance for supplemental acute care benefits for  
13 AFDC recipients and non-cash medicaid beneficiaries in  
14 a State for quarters in 1995 or any succeeding year—

15               “(1) no Federal financial participation shall be  
16 payable under section 1903(a)(1),

17               “(2) the State may receive payments for such  
18 supplemental acute care benefits under part B of  
19 title XXI, and

20               “(3) such a recipient or beneficiary is not enti-  
21 tled to receive any medical assistance for such bene-  
22 fits under the State plan under this title.”.

1 **Subtitle C—Increased State Flexi-**  
2 **bility in Contracting for Coordi-**  
3 **nated Care**

4 **SEC. 3201. MODIFICATION OF FEDERAL REQUIREMENTS TO**  
5 **ALLOW STATES MORE FLEXIBILITY IN CON-**  
6 **TRACTING FOR COORDINATED CARE SERV-**  
7 **ICES.**

8 (a) IN GENERAL.—

9 (1) PAYMENT PROVISIONS.—Section 1903(m)  
10 of the Social Security Act (42 U.S.C. 1396b(m)) is  
11 amended to read as follows:

12 “(m)(1) No payment shall be made under this title  
13 to a State with respect to expenditures incurred by such  
14 State for payment to an entity which is at risk (as defined  
15 in section 1932(a)(4)) for services provided by such entity  
16 to individuals eligible for medical assistance under the  
17 State plan under this title, unless the entity is a risk con-  
18 tracting entity (as defined in section 1932(a)(3)) and the  
19 State and such entity comply with the applicable provi-  
20 sions of section 1932.

21 “(2) No payment shall be made under this title to  
22 a State with respect to expenditures incurred by such  
23 State for payment for services provided to an individual  
24 eligible for medical assistance under the State plan under  
25 this title if such payment by the State is contingent upon

1 the individual receiving such services from a specified  
2 health care provider or subject to the approval of a speci-  
3 fied health care provider, unless the entity receiving pay-  
4 ment is a primary care case management entity (as de-  
5 fined in section 1932(a)(2)) and the State and such entity  
6 comply with the applicable provisions of section 1932.”.

7           (2) REQUIREMENTS FOR COORDINATED CARE  
8 SERVICES.—Title XIX of such Act (42 U.S.C. 1396  
9 et seq.), as amended by section 2001(a), is amended  
10 by redesignating section 1932 as section 1933 and  
11 by inserting after section 1931 the following new  
12 section:

13       “REQUIREMENTS FOR COORDINATED CARE SERVICES  
14       “SEC. 1932. (a) DEFINITIONS.—For purposes of this  
15 title—

16           “(1) PRIMARY CARE CASE MANAGEMENT PRO-  
17 GRAM.—The term ‘primary care case management  
18 program’ means a program operated by a State  
19 agency under which such State agency enters into  
20 contracts with primary care case management enti-  
21 ties for the provision of health care items and serv-  
22 ices which are specified in such contracts and the  
23 provision of case management services to individuals  
24 who are—

25                   “(A) eligible for medical assistance under  
26           the State plan,



1           “(B) enrolled with such primary care case  
2 management entities, and

3           “(C) entitled to receive such specified  
4 health care items and services and case man-  
5 agement services only as approved and ar-  
6 ranged for, or provided, by such entities.

7           “(2) PRIMARY CARE CASE MANAGEMENT EN-  
8 TITY.—The term ‘primary care case management  
9 entity’ means a health care provider which—

10           “(A) must be a physician, group of physi-  
11 cians, a Federally qualified health center, a  
12 rural health clinic, a community health author-  
13 ity (under section 1934), or an entity employing  
14 or having other arrangements with physicians  
15 operating under a contract with a State to pro-  
16 vide services under a primary care case man-  
17 agement program,

18           “(B) receives payment on a fee for service  
19 basis (or, in the case of a Federally qualified  
20 health center or a rural health clinic, on a rea-  
21 sonable cost per encounter basis) for the provi-  
22 sion of health care items and services specified  
23 in such contract to enrolled individuals,

24           “(C) receives an additional fixed fee per  
25 enrollee for a period specified in such contract

1           for providing case management services (includ-  
2           ing approving and arranging for the provision  
3           of health care items and services specified in  
4           such contract on a referral basis) to enrolled  
5           individuals, and

6           “(D) is not an entity that is at risk (as de-  
7           fined in paragraph (4)) for such case manage-  
8           ment services.

9           “(3) RISK CONTRACTING ENTITY.—The term  
10          ‘risk contracting entity’ means an entity which has  
11          a contract with the State agency (or a health insur-  
12          ing organization described in subsection (n)(2))  
13          under which the entity—

14               “(A) provides or arranges for the provision  
15               of health care items or services which are speci-  
16               fied in such contract to individuals eligible for  
17               medical assistance under the State plan, and

18               “(B) is at risk (as defined in paragraph  
19               (4)) for part or all of the cost of such items or  
20               services furnished to individuals eligible for  
21               medical assistance under such plan.

22           “(4) AT RISK.—The term ‘at risk’ means an  
23          entity which—

24               “(A) has a contract with the State agency  
25               under which such entity is paid a fixed amount

1 for providing or arranging for the provision of  
2 health care items or services specified in such  
3 contract to an individual eligible for medical as-  
4 sistance under the State plan and enrolled with  
5 such entity, regardless of whether such items or  
6 services are furnished to such individual, and

7 “(B) is liable for all or part of the cost of  
8 furnishing such items or services, regardless of  
9 whether such cost exceeds such fixed payment.

10 “(b) GENERAL REQUIREMENTS FOR RISK CON-  
11 TRACTING ENTITIES.—

12 “(1) ORGANIZATION.—A risk contracting entity  
13 meets the requirements of this section only if such  
14 entity—

15 “(A)(i) is a qualified health maintenance  
16 organization as defined in section 1310(d) of  
17 the Public Health Service Act, as determined by  
18 the Secretary pursuant to section 1312 of such  
19 Act; or

20 “(ii) is described in subparagraph (C), (D),  
21 (E), (F), or (G) of subsection (e)(4);

22 “(B) is a Federally qualified health center,  
23 a rural health clinic, or a community health au-  
24 thority (under section 1934) which has made  
25 adequate provision against the risk of insol-

1 vency (pursuant to the guidelines and regula-  
2 tions issued by the Secretary under this sec-  
3 tion), and ensures that individuals eligible for  
4 medical assistance under the State plan are not  
5 held liable for such entity's debts in case of  
6 such entity's insolvency; or

7 “(C) is an entity which meets all applicable  
8 State licensing requirements and has made ade-  
9 quate provision against the risk of insolvency  
10 (pursuant to the guidelines and regulations is-  
11 sued by the Secretary under this section), and  
12 ensures that individuals eligible for medical as-  
13 sistance under the State plan are not held liable  
14 for such entity's debts in case of such entity's  
15 insolvency.

16 “(2) GUARANTEES OF ENROLLEE ACCESS.—A  
17 risk contracting entity meets the requirements of  
18 this section only if—

19 “(A) the geographic locations, hours of op-  
20 eration, patient to staff ratios, and other rel-  
21 evant characteristics of such entity are suffi-  
22 cient to afford individuals eligible for medical  
23 assistance under the State plan access to such  
24 entities that is at least equivalent to the access  
25 to health care providers that would be available

1 to such individuals if such individuals were not  
2 enrolled with such entity;

3 “(B) such entity has reasonable and ade-  
4 quate hours of operation, including 24-hour  
5 availability of—

6 “(i)(I) treatment for an unforeseen ill-  
7 ness, injury, or condition of an individual  
8 eligible for medical assistance under the  
9 State plan and enrolled with such entity;  
10 or

11 “(II) referral to other health care pro-  
12 viders for such treatment; and

13 “(ii) other information, as determined  
14 by the Secretary or the State; and

15 “(C) such entity complies with such other  
16 requirements relating to access to care as the  
17 Secretary or the State may impose.

18 “(3) CONTRACT WITH STATE AGENCY.—A risk  
19 contracting entity meets the requirements of this  
20 section only if such entity has a written contract  
21 with the State agency which provides—

22 “(A) that the entity will comply with all  
23 applicable provisions of this section, that the  
24 State has the right to penalize the entity for  
25 failure to comply with such requirements and to

1 terminate the contract in accordance with sub-  
2 section (j), and that the entity will be subject  
3 to penalties imposed by the Secretary under  
4 subsection (i) for failure to comply with such  
5 requirements;

6 “(B) for a payment methodology based on  
7 experience rating or another actuarially sound  
8 methodology approved by the Secretary, which  
9 guarantees (as demonstrated by such models or  
10 formulas as the Secretary may approve) that—

11 “(i) payments to the entity under the  
12 contract shall not exceed an amount equal  
13 to 100 percent of the costs (which shall in-  
14 clude administrative costs and which may  
15 include costs for inpatient hospital services  
16 that would have been incurred in the ab-  
17 sence of such contract) that would have  
18 been incurred by the State agency in the  
19 absence of the contract; and

20 “(ii) the financial risk for inpatient  
21 hospital services is limited to an extent  
22 established by the State;

23 “(C) that the Secretary and the State (or  
24 any person or organization designated by ei-  
25 ther) shall have the right to audit and inspect

1 any books and records of the entity (and of any  
2 subcontractor) that pertain—

3 “(i) to the ability of the entity (or a  
4 subcontractor) to bear the risk of potential  
5 financial losses; or

6 “(ii) to services performed or deter-  
7 minations of amounts payable under the  
8 contract;

9 “(D) that in the entity’s enrollment,  
10 reenrollment, or disenrollment of individuals eli-  
11 gible for medical assistance under the State  
12 plan and eligible to enroll, reenroll, or disenroll  
13 with the entity pursuant to the contract, the en-  
14 tity will not discriminate among such individ-  
15 uals on the basis of such individuals’ health  
16 status or requirements for health care services;

17 “(E)(i) individuals eligible for medical as-  
18 sistance under the State plan who have enrolled  
19 with the entity are permitted to terminate such  
20 enrollment without cause as of the beginning of  
21 the first calendar month (or in the case of an  
22 entity described in subsection (e)(4), as of the  
23 beginning of the first enrollment period) follow-  
24 ing a full calendar month after a request is  
25 made for such termination;

1           “(ii) that when an individual has relocated  
2           outside the entity’s service area, and the entity  
3           has been notified of the relocation, services  
4           (within reasonable limits) furnished by a health  
5           care provider outside the service area will be re-  
6           imbursed either by the entity or by the State  
7           agency; and

8           “(iii) for written notification of each such  
9           individual’s right to terminate enrollment,  
10          which shall be provided at the time of such indi-  
11          vidual’s enrollment, and, in the case of a child  
12          with special health care needs as defined in sub-  
13          section (e)(1)(B)(ii), at the time the entity iden-  
14          tifies such a child;

15          “(F) in the case of services immediately re-  
16          quired to treat an unforeseen illness, injury, or  
17          condition, of an individual eligible for medical  
18          assistance under the State plan and enrolled  
19          with the entity—

20                 “(i) that such services shall not be  
21                 subject to a preapproval requirement; and

22                 “(ii) where such services are furnished  
23                 by a health care provider other than the  
24                 entity, for reimbursement of such provider  
25                 either by the entity or by the State agency;



1           “(G) for disclosure of information in ac-  
2 cordance with subsection (h) and section 1124;

3           “(H) that any physician incentive plan op-  
4 erated by the entity meets the requirements of  
5 section 1876(i)(8);

6           “(I) for maintenance of sufficient patient  
7 encounter data to identify the physician who de-  
8 livers services to patients;

9           “(J) that the entity will comply with the  
10 requirement of section 1902(w) with respect to  
11 each enrollee;

12           “(K) that the entity will implement a  
13 grievance system, inform enrollees in writing  
14 about how to use such grievance system, ensure  
15 that grievances are addressed in a timely man-  
16 ner, and report grievances to the State at inter-  
17 vals to be determined by the State;

18           “(L) that contracts between the entity and  
19 each subcontractor of such entity will require  
20 each subcontractor—

21           “(i) to cooperate with the entity in the  
22 implementation of its internal quality as-  
23 surance program under paragraph (4) and  
24 adhere to the standards set forth in the  
25 quality assurance program, including

standards with respect to access to care, facilities in which patients receive care, and availability, maintenance, and review of medical records;

“(ii) to cooperate with the Secretary, the State agency and any contractor to the State in monitoring and evaluating the quality and appropriateness of care provided to enrollees as required by Federal or State laws and regulations; and

“(iii) where applicable, to adhere to regulations and program guidance with respect to reporting requirements under section 1905(r);

“(M) that, where the State deems it necessary to ensure the timely provision to enrollees of the services listed in subsection (f)(2)(C)(ii), the State may arrange for the provision of such services by health care providers other than the entity and may adjust its payments to the entity accordingly;

“(N) that the entity and the State will comply with guidelines and regulations issued by the Secretary with respect to procedures for marketing and information that must be pro-

1           vided to individuals eligible for medical assist-  
2           ance under the State plan;

3           “(O) that the entity must provide pay-  
4           ments to hospitals for inpatient hospital serv-  
5           ices furnished to infants who have not attained  
6           the age of 1 year, and to children who have not  
7           attained the age of 6 years and who receive  
8           such services in a disproportionate share hos-  
9           pital, in accordance with paragraphs (2) and  
10          (3) of section 1902(s);

11          “(P) that the entity shall report to the  
12          State, at such time and in such manner as the  
13          State shall require, on the rates paid for hos-  
14          pital services (by type of hospital and type of  
15          service) furnished to individuals enrolled with  
16          the entity;

17          “(Q) detailed information regarding the  
18          relative responsibilities of the entity and the  
19          State, for providing (or arranging for the provi-  
20          sion of), and making payment for, the following  
21          items and services:

22                  “(i) immunizations;

23                  “(ii) the purchase of vaccines;

24                  “(iii) lead screening and treatment  
25          services;

1 “(iv) screening and treatment for tu-  
2 berculosis;

3 “(v) screening and treatment for, and  
4 preventive services related to, sexually  
5 transmitted diseases, including HIV infec-  
6 tion;

7 “(vi) screening, diagnostic, and treat-  
8 ment services required under section  
9 1905(r);

10 “(vii) family planning services;

11 “(viii) services prescribed under—

12 “(I) an Individual Education  
13 Plan or Individualized Family Service  
14 Plan under part B or part H of the  
15 Individuals with Disabilities Edu-  
16 cation Act; and

17 “(II) any other individual plan of  
18 care or treatment developed under  
19 this title or title V;

20 “(ix) transportation needed to obtain  
21 services to which the enrollee is entitled  
22 under the State plan or pursuant to an in-  
23 dividual plan of care or treatment de-  
24 scribed in subclauses (I) and (II) of clause  
25 (viii); and

1           “(x) such other services as the Sec-  
2           retary may specify;

3           “(R) detailed information regarding the  
4           procedures for coordinating the relative respon-  
5           sibilities of the entity and the State to ensure  
6           prompt delivery of, compliance with any appli-  
7           cable reporting requirements related to, and ap-  
8           propriate record keeping with respect to, the  
9           items and services described in subparagraph  
10          (Q); and

11          “(S) such other provisions as the Secretary  
12          may require.

13          “(4) INTERNAL QUALITY ASSURANCE.—A risk  
14          contracting entity meets the requirements of this  
15          section only if such entity has in effect a written in-  
16          ternal quality assurance program which includes a  
17          systematic process to achieve specified and measur-  
18          able goals and objectives for access to, and quality  
19          of, care, which—

20               “(A) identifies the organizational units re-  
21               sponsible for performing specific quality assur-  
22               ance functions, and ensures that such units are  
23               accountable to the governing body of the entity  
24               and that such units have adequate supervision,

1 staff, and other necessary resources to perform  
2 these functions effectively,

3 “(B) if any quality assurance functions are  
4 delegated to other entities, ensures that the risk  
5 contracting entity remains accountable for all  
6 quality assurance functions and has mecha-  
7 nisms to ensure that all quality assurance ac-  
8 tivities are carried out,

9 “(C) includes methods to ensure that phy-  
10 sicians and other health care professionals  
11 under contract with the entity are licensed or  
12 certified as required by State law, or are other-  
13 wise qualified to perform the services such phy-  
14 sicians and other professionals provide, and  
15 that these qualifications are ensured through  
16 appropriate credentialing and recredentialing  
17 procedures,

18 “(D) provides for continuous monitoring of  
19 the delivery of health care, through—

20 “(i) identification of clinical areas to  
21 be monitored, including immunizations,  
22 prenatal care, services required under sec-  
23 tion 1905(r), and other appropriate clinical  
24 areas, to reflect care provided to enrollees

1 eligible for medical assistance under the  
2 State plan,

3 “(ii) use of quality indicators and  
4 standards for assessing the quality and ap-  
5 propriateness of care delivered, and the  
6 availability and accessibility of all services  
7 for which the entity is responsible under  
8 such entity’s contract with the State,

9 “(iii) use of epidemiological data or  
10 chart review, as appropriate, and patterns  
11 of care overall,

12 “(iv) patient surveys, spot checks, or  
13 other appropriate methods to determine  
14 whether—

15 “(I) enrollees are able to obtain  
16 timely appointments with primary  
17 care providers and specialists, and

18 “(II) enrollees are otherwise  
19 guaranteed access and care as pro-  
20 vided under paragraph (2),

21 “(v) provision of written information  
22 to health care providers and other person-  
23 nel on the outcomes, quality, availability,  
24 accessibility, and appropriateness of care,  
25 and

1                   “(vi) implementation of corrective ac-  
2                   tions,

3                   “(E) includes standards for timely enrollee  
4                   access to information and care which at a mini-  
5                   mum shall incorporate standards used by the  
6                   State or professional or accreditation bodies for  
7                   facilities furnishing perinatal and neonatology  
8                   care and other forms of specialized medical and  
9                   surgical care,

10                  “(F) includes standards for the facilities in  
11                  which patients receive care,

12                  “(G) includes standards for managing and  
13                  treating medical conditions prevalent among  
14                  such entity’s enrollees eligible for medical as-  
15                  sistance under the State plan,

16                  “(H) includes mechanisms to ensure that  
17                  enrollees eligible for medical assistance under  
18                  the State plan receive services for which the en-  
19                  tity is responsible under the contract which are  
20                  consistent with standards established by the ap-  
21                  plicable professional societies or government  
22                  agencies,

23                  “(I) includes standards for the availability,  
24                  maintenance, and review of medical records



1 consistent with generally accepted medical prac-  
2 tice,

3 “(J) provides for dissemination of quality  
4 assurance procedures to health care providers  
5 under contract with the entity, and

6 “(K) meets any other requirements pre-  
7 scribed by the Secretary or the State.

8 “(5) TRANSITIONAL AGREEMENTS WITH ESSEN-  
9 TIAL COMMUNITY PROVIDERS.—A risk contracting  
10 entity meets the requirements of this section only if  
11 such entity complies with the requirements of section  
12 1013 of the Bipartisan Health Care Reform Act of  
13 1994 (subject to the sunset contained in subsection  
14 (j) of such section).

15 “(c) GENERAL REQUIREMENTS FOR PRIMARY CARE  
16 CASE MANAGEMENT PROGRAMS.—A primary care case  
17 management program implemented by a State under this  
18 section shall—

19 “(1) provide that each primary care case man-  
20 agement entity participating in such program has a  
21 written contract with the State agency,

22 “(2) include methods for selection and monitor-  
23 ing of participating primary care case management  
24 entities to ensure—

1           “(A) that the geographic locations, hours  
2 of operation, patient to staff ratio, and other  
3 relevant characteristics of such entities are suf-  
4 ficient to afford individuals eligible for medical  
5 assistance under the State plan access to such  
6 entities that is at least equivalent to the access  
7 to health care providers that would be available  
8 to such individuals if such individuals were not  
9 enrolled with such entity,

10           “(B) that such entities and their profes-  
11 sional personnel are licensed as required by  
12 State law and qualified to provide case manage-  
13 ment services, through methods such as ongo-  
14 ing monitoring of compliance with applicable re-  
15 quirements and providing information and tech-  
16 nical assistance, and

17           “(C) that such entities—

18           “(i) provide timely and appropriate  
19 primary care to such enrollees consistent  
20 with standards established by applicable  
21 professional societies or governmental  
22 agencies, or such other standards pre-  
23 scribed by the Secretary or the State, and

24           “(ii) where other items and services  
25 are determined to be medically necessary,

1           give timely approval of such items and  
2           services and referral to appropriate health  
3           care providers,

4           “(3) provide that no preapproval shall be re-  
5           quired for emergency health care items or services,  
6           and

7           “(4) permit individuals eligible for medical as-  
8           sistance under the State plan who have enrolled with  
9           a primary care case management entity to terminate  
10          such enrollment without cause not later than the be-  
11          ginning of the first calendar month following a full  
12          calendar month after the request is made for such  
13          termination.

14          “(d) EXEMPTIONS FROM STATE PLAN REQUIRE-  
15          MENTS.—A State plan may permit or require an individ-  
16          ual eligible for medical assistance under such plan to en-  
17          roll with a risk contracting entity or a primary care case  
18          management entity without regard to the requirements set  
19          forth in the following paragraphs of section 1902(a):

20               “(1) Paragraph (1) (concerning statewideness).

21               “(2) Paragraph (10)(B) (concerning com-  
22          parability of benefits), to the extent benefits not in-  
23          cluded in the State plan are provided.

24               “(3) Paragraph (23) (concerning freedom of  
25          choice of provider), except with respect to services

1 described in section 1905(a)(4)(C) and except as re-  
2 quired under subsection (e).

3 “(e) STATE OPTIONS WITH RESPECT TO ENROLL-  
4 MENT AND DISENROLLMENT.—

5 “(1) MANDATORY ENROLLMENT.—

6 “(A) IN GENERAL.—Except as provided in  
7 subparagraph (B), a State plan may require an  
8 individual eligible for medical assistance under  
9 such plan to enroll with a risk contracting en-  
10 tity or a primary care case management entity  
11 only if the individual is permitted a choice with-  
12 in a reasonable service area (as defined by the  
13 State)—

14 “(i) between or among 2 or more risk  
15 contracting entities,

16 “(ii) among a risk contracting entity  
17 and a primary care case management pro-  
18 gram, or

19 “(iii) among primary care case man-  
20 agement entities.

21 “(B) SPECIAL NEEDS CHILDREN.—

22 “(i) IN GENERAL.—A State may not  
23 require a child with special health care  
24 needs (as defined in clause (ii)) to enroll

1 with a risk contracting entity or a primary  
2 care case management entity.

3 “(ii) DEFINITION.—For purposes of  
4 this subparagraph, the term ‘child with  
5 special health care needs’ refers to an indi-  
6 vidual eligible for supplemental security in-  
7 come under title XVI, a child described  
8 under section 501(a)(1)(D), or a child de-  
9 scribed in section 1902(e)(3).

10 “(2) REENROLLMENT OF INDIVIDUALS WHO  
11 REGAIN ELIGIBILITY.—In the case of an individual  
12 who—

13 “(A) in a month is eligible for medical as-  
14 sistance under the State plan and enrolled with  
15 a risk contracting entity with a contract under  
16 this section,

17 “(B) in the next month (or next 2 months)  
18 is not eligible for such medical assistance, but

19 “(C) in the succeeding month is again eli-  
20 gible for such benefits,

21 the State agency (subject to subsection (b)(3)(E))  
22 may enroll the individual for that succeeding month  
23 with such entity, if the entity continues to have a  
24 contract with the State agency under this sub-  
25 section.

1 “(3) DISENROLLMENT.—

2 “(A) RESTRICTIONS ON DISENROLLMENT  
3 WITHOUT CAUSE.—Except as provided in sub-  
4 paragraph (C), a State plan may restrict the  
5 period in which individuals enrolled with risk  
6 contracting entities described in paragraph (4)  
7 may terminate such enrollment without cause to  
8 the first month of each period of enrollment (as  
9 defined in subparagraph (B)), but only if the  
10 State provides notification, at least once during  
11 each such enrollment period, to individuals en-  
12 rolled with such entity of the right to terminate  
13 such enrollment and the restriction on the exer-  
14 cise of this right. Such restriction shall not  
15 apply to requests for termination of enrollment  
16 for cause.

17 “(B) PERIOD OF ENROLLMENT.—For pur-  
18 poses of this paragraph, the term ‘period of en-  
19 rollment’ means—

20 “(i) a period not to exceed 6 months  
21 in duration, or

22 “(ii) a period not to exceed 1 year in  
23 duration, in the case of a State that, on  
24 the effective date of this paragraph, had in  
25 effect a waiver under section 1115 of re-

1           quirements under this title under which  
2           the State could establish a 1-year mini-  
3           mum period of enrollment with risk con-  
4           tracting entities.

5           “(C) SPECIAL NEEDS CHILDREN.—A State  
6           may not restrict disenrollment of a child with  
7           special health care needs (as defined in para-  
8           graph (1)(B)(ii)).

9           “(4) ENTITIES ELIGIBLE FOR DISENROLLMENT  
10          RESTRICTIONS.—A risk contracting entity described  
11          in this paragraph is—

12           “(A) a qualified health maintenance orga-  
13           nization as defined in section 1310(d) of the  
14           Public Health Service Act,

15           “(B) an eligible organization with a con-  
16           tract under section 1876,

17           “(C) an entity that is receiving (and has  
18           received during the previous 2 years) a grant of  
19           at least \$100,000 under section 329(d)(1)(A)  
20           or 330(d)(1) of the Public Health Service Act,

21           “(D) an entity that—

22           “(i) received a grant of at least  
23           \$100,000 under section 329(d)(1)(A) or  
24           section 330(d)(1) of the Public Health  
25           Service Act in the fiscal year ending June

1           30, 1976, and has been a grantee under ei-  
2           ther such section for all periods after that  
3           date, and

4           “(ii) provides to its enrollees, on a  
5           prepaid capitation or other risk basis, all  
6           of the services described in paragraphs (1),  
7           (2), (3), (4)(C), and (5) of section 1905(a)  
8           (and the services described in section  
9           1905(a)(7), to the extent required by sec-  
10          tion 1902(a)(10)(D)),

11          “(E) an entity that is receiving (and has  
12          received during the previous 2 years) at least  
13          \$100,000 (by grant, subgrant, or subcontract)  
14          under the Appalachian Regional Development  
15          Act of 1965,

16          “(F) a nonprofit primary health care en-  
17          tity located in a rural area (as defined by the  
18          Appalachian Regional Commission)—

19               “(i) which received in the fiscal year  
20               ending June 30, 1976, at least \$100,000  
21               (by grant, subgrant, or subcontract) under  
22               the Appalachian Regional Development Act  
23               of 1965, and

24               “(ii) which, for all periods after such  
25               date, either has been the recipient of a



1 grant, subgrant, or subcontract under such  
2 Act or has provided services on a prepaid  
3 capitation or other risk basis under a con-  
4 tract with the State agency initially en-  
5 tered into during a year in which the entity  
6 was the recipient of such a grant,  
7 subgrant, or subcontract,

8 “(G) an entity that had contracted with  
9 the State agency prior to 1970 for the provi-  
10 sion, on a prepaid risk basis, of services (which  
11 did not include inpatient hospital services) to  
12 individuals eligible for medical assistance under  
13 the State plan,

14 “(H) a program pursuant to an undertak-  
15 ing described in subsection (n)(3) in which at  
16 least 25 percent of the membership enrolled on  
17 a prepaid basis are individuals who—

18 “(i) are not insured for benefits under  
19 part B of title XVIII or eligible for medical  
20 assistance under the State plan, and

21 “(ii) (in the case of such individuals  
22 whose prepayments are made in whole or  
23 in part by any government entity) had the  
24 opportunity at the time of enrollment in  
25 the program to elect other coverage of

1 health care costs that would have been  
2 paid in whole or in part by any govern-  
3 mental entity,

4 “(I) an entity that, on the date of enact-  
5 ment of this provision, had a contract with the  
6 State agency under a waiver under section 1115  
7 or 1915(b) and was not subject to a require-  
8 ment under this title to permit disenrollment  
9 without cause, or

10 “(J) an entity that has a contract with the  
11 State agency under a waiver under section  
12 1915(b)(5).

13 “(f) STATE MONITORING AND EXTERNAL REVIEW.—

14 “(1) STATE GRIEVANCE PROCEDURE.—A State  
15 contracting with a risk contracting entity or a pri-  
16 mary care case management entity under this sec-  
17 tion shall provide for a grievance procedure for en-  
18 rollees of such entity with at least the following ele-  
19 ments:

20 “(A) A toll-free telephone number for en-  
21 rollee questions and grievances.

22 “(B) Periodic notification of enrollees of  
23 their rights with respect to such entity or pro-  
24 gram.

1           “(C) Periodic sample reviews of grievances  
2 registered with such entity or program or with  
3 the State.

4           “(D) Periodic survey and analysis of en-  
5 rollee satisfaction with such entity or program,  
6 including interviews with individuals who  
7 disenroll from the entity or program.

8           “(2) STATE MONITORING OF QUALITY AND AC-  
9 CESS.—

10           “(A) RISK CONTRACTING ENTITIES.—A  
11 State contracting with a risk contracting entity  
12 under this section shall provide for ongoing  
13 monitoring of such entity’s compliance with the  
14 requirements of subsection (b), including com-  
15 pliance with the requirements of such entity’s  
16 contract under subsection (b)(3), and shall un-  
17 dertake appropriate followup activities to ensure  
18 that any problems identified are rectified and  
19 that compliance with the requirements of sub-  
20 section (b) and the requirements of the contract  
21 under subsection (b)(3) is maintained.

22           “(B) PRIMARY CARE CASE MANAGEMENT  
23 ENTITIES.—A State electing to implement a  
24 primary care case management program shall  
25 provide for ongoing monitoring of the pro-

1       gram’s compliance with the requirements of  
2       subsection (c) and shall undertake appropriate  
3       followup activities to ensure that any problems  
4       identified are rectified and that compliance with  
5       subsection (c) is maintained.

6               “(C) SERVICES.—

7               “(i) IN GENERAL.—The State shall  
8       establish procedures (in addition to those  
9       required under subparagraphs (A) and  
10      (B)) to ensure that the services listed in  
11      clause (ii) are available in a timely manner  
12      to an individual enrolled with a risk con-  
13      tracting entity or a primary care case man-  
14      agement entity. Where necessary to ensure  
15      the timely provision of such services, the  
16      State shall arrange for the provision of  
17      such services by health care providers  
18      other than the risk contracting entity or  
19      the primary care case management entity  
20      in which an individual is enrolled.

21              “(ii) SERVICES LISTED.—The services  
22      listed in this clause are—

23                      “(I) prenatal care;

24                      “(II) immunizations;

1 “(III) lead screening and treat-  
2 ment;

3 “(IV) prevention, diagnosis and  
4 treatment of tuberculosis, sexually  
5 transmitted diseases (including HIV  
6 infection), and other communicable  
7 diseases; and

8 “(V) such other services as the  
9 Secretary may specify.

10 “(iii) REPORT.—The procedures re-  
11 ferred to in clause (i) shall be described in  
12 an annual report to the Secretary provided  
13 by the State.

14 “(3) EXTERNAL INDEPENDENT REVIEW.—

15 “(A) IN GENERAL.—Except as provided in  
16 paragraph (4), a State contracting with a risk  
17 contracting entity under this section shall pro-  
18 vide for an annual external independent review  
19 of the quality and timeliness of, and access to,  
20 the items and services specified in such entity’s  
21 contract with the State agency. Such review  
22 shall be conducted by a utilization control and  
23 peer review organization with a contract under  
24 section 1153 or another organization unaffili-  
25 ated with the State government or with any

1 risk contracting entity and approved by the  
2 Secretary.

3 “(B) CONTENTS OF REVIEW.—An external  
4 independent review conducted under this para-  
5 graph shall include the following:

6 “(i) A review of the entity’s medical  
7 care, through sampling of medical records  
8 or other appropriate methods, for indica-  
9 tions of quality of care and inappropriate  
10 utilization (including overutilization) and  
11 treatment.

12 “(ii) A review of enrollee inpatient  
13 and ambulatory data, through sampling of  
14 medical records or other appropriate meth-  
15 ods, to determine trends in quality and ap-  
16 propriateness of care.

17 “(iii) Notification of the entity and  
18 the State when the review under this para-  
19 graph indicates inappropriate care, treat-  
20 ment, or utilization of services (including  
21 overutilization).

22 “(iv) Other activities as prescribed by  
23 the Secretary or the State.

24 “(C) AVAILABILITY.—The results of each  
25 external independent review conducted under

1           this paragraph shall be available to the public  
2           consistent with the requirements for disclosure  
3           of information contained in section 1160.

4           “(4) DEEMED COMPLIANCE WITH EXTERNAL  
5           INDEPENDENT QUALITY OF CARE REVIEW REQUIRE-  
6           MENTS.—

7                   “(A) IN GENERAL.—The Secretary may  
8           deem the State to have fulfilled the requirement  
9           for independent external review of quality of  
10          care with respect to an entity which has been  
11          accredited by an organization described in sub-  
12          paragraph (B) and approved by the Secretary.

13                   “(B) ACCREDITING ORGANIZATION.—An  
14          accrediting organization described in this sub-  
15          paragraph must—

16                           “(i) exist for the primary purpose of  
17                          accrediting coordinated care organizations;

18                           “(ii) be governed by a group of indi-  
19                          viduals representing health care providers,  
20                          purchasers, regulators, and consumers (a  
21                          minority of which shall be representatives  
22                          of health care providers);

23                           “(iii) have substantial experience in  
24                          accrediting coordinated care organizations,

1 including an organization's internal quality  
2 assurance program;

3 “(iv) be independent of health care  
4 providers or associations of health care  
5 providers;

6 “(v) be a nonprofit organization; and

7 “(vi) have an accreditation process  
8 which meets requirements specified by the  
9 Secretary.

10 “(5) FEDERAL MONITORING RESPONSIBIL-  
11 ITIES.—The Secretary shall review the external inde-  
12 pendent reviews conducted pursuant to paragraph  
13 (3) and shall monitor the effectiveness of the State's  
14 monitoring and followup activities required under  
15 subparagraph (A) of paragraph (2). If the Secretary  
16 determines that a State's monitoring and followup  
17 activities are not adequate to ensure that the re-  
18 quirements of paragraph (2) are met, the Secretary  
19 shall undertake appropriate followup activities to en-  
20 sure that the State improves its monitoring and fol-  
21 lowup activities.

22 “(g) PARTICIPATION OF CERTAIN PROVIDERS.—  
23 Each risk contracting entity shall meet the requirements  
24 of section 1013 of the Bipartisan Health Care Reform Act



1 of 1994 in the same manner as they would apply to a  
2 group health plan (when such section becomes effective).

3 “(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

4 “(1) IN GENERAL.—Each risk contracting en-  
5 tity which is not a qualified health maintenance or-  
6 ganization (as defined in section 1310(d) of the  
7 Public Health Service Act) must report to the State  
8 and, upon request, to the Secretary, the Inspector  
9 General of the Department of Health and Human  
10 Services, and the Comptroller General of the United  
11 States a description of transactions between the en-  
12 tity and a party in interest (as defined in section  
13 1318(b) of such Act), including the following trans-  
14 actions:

15 “(A) Any sale or exchange, or leasing of  
16 any property between the entity and such a  
17 party.

18 “(B) Any furnishing for consideration of  
19 goods, services (including management serv-  
20 ices), or facilities between the entity and such  
21 a party, but not including salaries paid to em-  
22 ployees for services provided in the normal  
23 course of their employment.

1           “(C) Any lending of money or other exten-  
2           sion of credit between the entity and such a  
3           party.

4           The State or the Secretary may require that infor-  
5           mation reported with respect to a risk contracting  
6           entity which controls, or is controlled by, or is under  
7           common control with, another entity be in the form  
8           of a consolidated financial statement for the risk  
9           contracting entity and such entity.

10          “(2) AVAILABILITY OF INFORMATION.—Each  
11          risk contracting entity shall make the information  
12          reported pursuant to paragraph (1) available to its  
13          enrollees upon reasonable request.

14          “(i) REMEDIES FOR FAILURE TO COMPLY.—

15          “(1) IN GENERAL.—If the Secretary determines  
16          that a risk contracting entity or a primary care case  
17          management entity—

18               “(A) fails substantially to provide services  
19               required under section 1905(r), when such an  
20               entity is required to do so, or provide medically  
21               necessary items and services that are required  
22               to be provided to an individual enrolled with  
23               such an entity, if the failure has adversely af-  
24               fected (or has substantial likelihood of adversely  
25               affecting) the individual;

1           “(B) imposes premiums on individuals en-  
2           rolled with such an entity in excess of the pre-  
3           miums permitted under this title;

4           “(C) acts to discriminate among individ-  
5           uals in violation of the provision of subsection  
6           (b)(3)(D), including expulsion or refusal to  
7           reenroll an individual or engaging in any prac-  
8           tice that would reasonably be expected to have  
9           the effect of denying or discouraging enrollment  
10          (except as permitted by this section) by eligible  
11          individuals with the entity whose medical condi-  
12          tion or history indicates a need for substantial  
13          future medical services;

14          “(D) misrepresents or falsifies information  
15          that is furnished—

16                 “(i) to the Secretary or the State  
17                 under this section; or

18                 “(ii) to an individual or to any other  
19                 entity under this section; or

20          “(E) fails to comply with the requirements  
21          of section 1876(i)(8),

22          the Secretary may provide, in addition to any other  
23          remedies available under law, for any of the rem-  
24          edies described in paragraph (2).

1           “(2) ADDITIONAL REMEDIES.—The remedies  
2 described in this paragraph are—

3           “(A) civil money penalties of not more  
4 than \$25,000 for each determination under  
5 paragraph (1), or, with respect to a determina-  
6 tion under subparagraph (C) or (D)(i) of such  
7 paragraph, of not more than \$100,000 for each  
8 such determination, plus, with respect to a de-  
9 termination under paragraph (1)(B), double the  
10 excess amount charged in violation of such  
11 paragraph (and the excess amount charged  
12 shall be deducted from the penalty and returned  
13 to the individual concerned), and plus, with re-  
14 spect to a determination under paragraph  
15 (1)(C), \$15,000 for each individual not enrolled  
16 as a result of a practice described in such para-  
17 graph, or

18           “(B) denial of payment to the State for  
19 medical assistance furnished by a risk contract-  
20 ing entity or a primary care case management  
21 entity under this section for individuals enrolled  
22 after the date the Secretary notifies the entity  
23 of a determination under paragraph (1) and  
24 until the Secretary is satisfied that the basis for

1           such determination has been corrected and is  
2           not likely to recur.

3       The provisions of section 1128A (other than sub-  
4       sections (a) and(b)) shall apply to a civil money pen-  
5       alty under subparagraph (A) in the same manner as  
6       such provisions apply to a penalty or proceeding  
7       under section 1128A(a).

8       “(j) TERMINATION OF CONTRACT BY STATE.—Any  
9       State which has a contract with a risk contracting entity  
10      or a primary care case management entity may terminate  
11      such contract if such entity fails to comply with the terms  
12      of such contract or any applicable provision of this section.

13      “(k) FAIR HEARING.—Nothing in this section shall  
14      affect the rights of an individual eligible to receive medical  
15      assistance under the State plan to obtain a fair hearing  
16      under section 1902(a)(3) or under applicable State law.

17      “(l) DISPROPORTIONATE SHARE HOSPITALS.—Noth-  
18      ing in this section shall affect any requirement on a State  
19      to comply with section 1923.

20      “(m) REFERRAL PAYMENTS.—For 1 year following  
21      the date on which individuals eligible for medical assist-  
22      ance under the State plan in a service area are required  
23      to enroll with a risk contracting entity or a primary care  
24      case management entity, Federally qualified health cen-  
25      ters and rural health centers located in such service area

1 or providing care to such enrollees, shall receive a fee for  
2 educating such enrollees about the availability of services  
3 from the risk contracting entity or primary care case man-  
4 agement entity with which such enrollees are enrolled.

5 “(n) SPECIAL RULES.—

6 “(1) NONAPPLICABILITY OF CERTAIN PROVI-  
7 SIONS TO CERTAIN RISK CONTRACTING ENTITIES.—

8 In the case of any risk contracting entity which—

9 “(A)(i) is an individual physician or a phy-  
10 sician group practice of less than 50 physicians,  
11 and

12 “(ii) is not described in paragraphs (A)  
13 and (B) of subsection (b)(1), and

14 “(B) is at risk only for the health care  
15 items and services directly provided by such en-  
16 tity,

17 paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4)  
18 of subsection (b), and paragraph (3) of subsection  
19 (f), shall not apply to such entity.

20 “(2) EXCEPTION FROM DEFINITION OF RISK  
21 CONTRACTING ENTITY.—For purposes of this sec-  
22 tion, the term ‘risk contracting entity’ shall not in-  
23 clude a health insuring organization which was used  
24 by a State before April 1, 1986, to administer a por-

1       tion of the State plan of such State on a statewide  
2       basis.

3           “(3) NEW JERSEY.—The rules under section  
4       1903(m)(6) as in effect on the day before the effec-  
5       tive date of this section shall apply in the case of an  
6       undertaking by the State of New Jersey (as de-  
7       scribed in such section 1903(m)(6)).

8           “(o) CONTINUATION OF CERTAIN COORDINATED  
9       CARE PROGRAMS.—The Secretary may provide for the  
10      continuation of any coordinated care program operating  
11      under section 1115 or 1915 without requiring compliance  
12      with any provision of this section which conflicts with the  
13      continuation of such program and without requiring any  
14      additional waivers under such sections 1115 and 1915 if  
15      the program has been successful in assuring quality and  
16      containing costs (as determining by the Secretary) and is  
17      likely to continue to be successful in the future.

18          “(p) GUIDELINES, REGULATIONS, AND MODEL CON-  
19      TRACT.—

20           “(1) GUIDELINES AND REGULATIONS ON SOL-  
21      VENCY.—At the earliest practicable time after the  
22      date of enactment of this section, the Secretary shall  
23      issue guidelines and regulations concerning solvency  
24      standards for risk contracting entities and sub-  
25      contractors of such risk contracting entities. Such

1 guidelines and regulations shall take into account  
2 characteristics that may differ among risk contract-  
3 ing entities including whether such an entity is at  
4 risk for inpatient hospital services.

5 “(2) GUIDELINES AND REGULATIONS ON MAR-  
6 KETING.—At the earliest practicable time after the  
7 date of enactment of this section, the Secretary shall  
8 issue guidelines and regulations concerning—

9 “(A) marketing undertaken by any risk  
10 contracting entity or any primary care case  
11 management program to individuals eligible for  
12 medical assistance under the State plan, and

13 “(B) information that must be provided by  
14 States or any such entity to individuals eligible  
15 for medical assistance under the State plan  
16 with respect to—

17 “(i) the options and rights of such in-  
18 dividuals to enroll with, and disenroll from,  
19 any such entity, as provided in this section,  
20 and

21 “(ii) the availability of services from  
22 any such entity (including a list of services  
23 for which such entity is responsible or  
24 must approve and information on how to



1           obtain services for which such entity is not  
2           responsible).

3       In developing the guidelines and regulations under  
4       this paragraph, the Secretary shall address the spe-  
5       cial circumstances of children with special health  
6       care needs (as defined in subsection (e)(1)(B)(ii))  
7       and other individuals with special health care needs.

8           “(3) MODEL CONTRACT.—The Secretary shall  
9       develop a model contract to reflect the requirements  
10      of subsection (b)(3) and such other requirements as  
11      the Secretary determines appropriate.”.

12      (b) WAIVERS FROM REQUIREMENTS ON COORDI-  
13      NATED CARE PROGRAMS.—Section 1915(b) of such Act  
14      (42 U.S.C. 1396n) is amended—

15           (1) in the matter preceding paragraph (1), by  
16           striking “as may be necessary” and inserting “, and  
17           section 1932 as may be necessary”;

18           (2) in paragraph (1), by striking “a primary  
19           care case management system or”;

20           (3) by striking “and” at the end of paragraph  
21           (3);

22           (4) by striking the period at the end of para-  
23           graph (4) and inserting “, and”; and

24           (5) by inserting after paragraph (4) the follow-  
25           ing new paragraph:

1 “(5) to permit a risk contracting entity (as de-  
2 fined in section 1932(a)(3)) to restrict the period in  
3 which individuals enrolled with such entity may ter-  
4minate such enrollment without cause in accordance  
5 with section 1932(e)(3)(A).”.

6 (c) STATE OPTION TO GUARANTEE MEDICAID ELIGI-  
7 BILITY.—Section 1902(e)(2) of such Act (42 U.S.C.  
8 1396a(e)(2)) is amended—

9 (1) in subparagraph (A), by striking all that  
10 precedes “(but for this paragraph)” and inserting  
11 “In the case of an individual who is enrolled—

12 “(i) with a qualified health maintenance  
13 organization (as defined in title XIII of the  
14 Public Health Service Act) or with a risk con-  
15tracting entity (as defined in section  
16 1932(a)(3)), or

17 “(ii) with any risk contracting entity (as  
18 defined in section 1932(a)(3)) in a State that,  
19 on the effective date of this provision, had in ef-  
20fect a waiver under section 1115 of require-  
21ments under this title under which the State  
22 could extend eligibility for medical assistance  
23 for enrollees of such entity, or

24 “(iii) with an eligible organization with a  
25 contract under section 1876,

1 and who would”,

2 (2) in subparagraph (B), by striking “organiza-  
3 tion or” each place it appears, and

4 (3) by adding at the end the following new sub-  
5 paragraph:

6 “(C) The State plan may provide, notwith-  
7 standing any other provision of this title, that  
8 an individual shall be deemed to continue to be  
9 eligible for benefits under this title until the end  
10 of the month following the month in which such  
11 individual would (but for this paragraph) lose  
12 such eligibility because of excess income and re-  
13 sources, if the individual is enrolled with a risk  
14 contracting entity or primary care case manage-  
15 ment entity (as those terms are defined in sec-  
16 tion 1932(a)).”.

17 (d) ENHANCED MATCH RELATED TO QUALITY  
18 REVIEW.—Section 1903(a)(3)(C) of such Act (42 U.S.C.  
19 1396b(a)(3)(C)) is amended—

20 (1) by striking “organization or by” and insert-  
21 ing “organization, by”; and

22 (2) by striking “section 1152, as determined by  
23 the Secretary,” and inserting “section 1152, as de-  
24 termined by the Secretary, or by another organiza-  
25 tion approved by the Secretary which is unaffiliated

1 with the State government or with any risk contract-  
2 ing entity (as defined in section 1932(a)(3)),”.

3 (e) ACCUMULATION OF RESERVES BY CERTAIN EN-  
4 TITIES.—Any organization referred to in section 329, 330,  
5 or 340, of the Public Health Service Act which has con-  
6 tracted with a State agency as a risk contracting entity  
7 under section 1932(g)(3)(A) of the Social Security Act  
8 may accumulate reserves with respect to payments made  
9 to such organization under section 1932(g)(3)(C) of such  
10 Act.

11 (f) CONFORMING AMENDMENTS.—

12 (1) Section 1128(b)(6)(C)(i) of such Act (42  
13 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking  
14 “health maintenance organization” and inserting  
15 “risk contracting entity”.

16 (2) Section 1902(a)(23) of such Act (42 U.S.C.  
17 1396a(a)(23)) is amended by striking “primary  
18 care-case management system (described in section  
19 1915(b)(1)), a health maintenance organization,”  
20 and inserting “primary care case management pro-  
21 gram (as defined in section 1932(a)(1)), a risk con-  
22 tracting entity (as defined in section 1932(a)(3)),”.

23 (3) Section 1902(a)(30)(C) of such Act (42  
24 U.S.C. 1396a(a)(30)(C)) is amended by striking  
25 “use a utilization” and all that follows through

1       “with the results” and inserting “provide for inde-  
2       pendent review and quality assurance of entities with  
3       contracts under section 1932, in accordance with  
4       subsection (f) of such section 1932, with the re-  
5       sults”.

6           (4) Section 1902(a)(57) of such Act (42 U.S.C.  
7       1396a(a)(57)) is amended by striking “or health  
8       maintenance organization (as defined in section  
9       1903(m)(1)(A))” and inserting “risk contracting en-  
10      tity, or primary care case management entity (as de-  
11      fined in section 1932(a))”.

12          (5) Section 1902(a) of such Act (42 U.S.C.  
13       1396a), as amended by sections 3303(a)(1) and  
14       3002(a), is amended—

15           (A) by striking “and” at the end of para-  
16       graph (61);

17           (B) by striking the period at the end of  
18       paragraph (62) and inserting “; and”; and

19           (C) by inserting after paragraph (62) the  
20       following new paragraphs:

21           “(63) at State option, provide for a primary  
22       care case management program in accordance with  
23       section 1932; and

1           “(64) at State option, provide for a program  
2           under which the State contracts with risk contract-  
3           ing entities in accordance with section 1932.”.

4           (6) Section 1902(p)(2) of such Act (42 U.S.C.  
5           1396a(p)(2)) is amended by striking “health mainte-  
6           nance organization (as defined in section 1903(m))”  
7           and inserting “risk contracting entity (as defined in  
8           section 1932(a)(3))”.

9           (7) Section 1902(w) of such Act (42 U.S.C.  
10          1396a(w)) is amended—

11           (A) in paragraph (1), by striking “section  
12           1903(m)(1)(A)” and inserting “section  
13           1932(a)(3)”, and

14           (B) in paragraph (2)(E)—

15           (i) by striking “health maintenance  
16           organization” and inserting “risk contract-  
17           ing entity”, and

18           (ii) by striking “organization” and in-  
19           serting “entity”.

20          (8) Section 1903(k) of such Act (42 U.S.C.  
21          1396b(k)) is amended by striking “health mainte-  
22          nance organization which meets the requirements of  
23          subsection (m) of this section” and inserting “risk  
24          contracting entity which meets the requirements of  
25          section 1932”.

1           (9) Section 1903(w)(7)(A)(viii) of such Act (42  
2       U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking  
3       “health maintenance organizations (and other orga-  
4       nizations with contracts under section 1903(m))”  
5       and inserting “risk contracting entities with con-  
6       tracts under section 1932”.

7           (10) Section 1905(a) of such Act (42 U.S.C.  
8       1396d(a)) is amended, in the matter preceding  
9       clause (i), by inserting “(which may be on a prepaid  
10      capitation or other risk basis)” after “payment”.

11          (11) Section 1916(b)(2)(D) of such Act (42  
12      U.S.C. 1396o(b)(2)(D)) is amended by striking  
13      “health maintenance organization (as defined in sec-  
14      tion 1903(m))” and inserting “risk contracting en-  
15      tity (as defined in section 1932(a)(3))”.

16          (12) Section 1925(b)(4)(D)(iv) of such Act (42  
17      U.S.C. 1396r-6(b)(4)(D)(iv)) is amended—

18               (A) in the heading, by striking “**HMO**”  
19               and inserting “**RISK CONTRACTING ENTITY**”,

20               (B) by striking “health maintenance orga-  
21               nization (as defined in section 1903(m)(1)(A))”  
22               and inserting “risk contracting entity (as de-  
23               fined in section 1932(a)(3))”, and

24               (C) by striking “health maintenance orga-  
25               nization in accordance with section 1903(m)”

1           and inserting “risk contracting entity in accord-  
2           ance with section 1932”.

3           (13) Paragraphs (1) and (2) of section 1926(a)  
4           of such Act (42 U.S.C. 1396r-7(a)) are each amend-  
5           ed by striking “health maintenance organizations  
6           under section 1903(m)” and inserting “risk con-  
7           tracting entities under section 1932”.

8           (14) Section 1927(j)(1) of such Act is amended  
9           by striking “\* \* \* Health Maintenance Organiza-  
10          tions, including those organizations that contract  
11          under section 1903(m)” and inserting “risk con-  
12          tracting entities (as defined in section 1932(a)(3))”.

13          (g) EFFECTIVE DATE.—The amendments made by  
14          this section shall become effective with respect to calendar  
15          quarters beginning on or after January 1, 1995.

16           **Subtitle D—Additional Medicaid**  
17                           **Reforms**

18   **SEC. 3301. REDUCTION IN AMOUNT OF PAYMENT ADJUST-**  
19                           **MENTS FOR DISPROPORTIONATE SHARE**  
20                           **HOSPITALS.**

21          (a) IN GENERAL.—Section 1923 of the Social Secu-  
22          rity Act (42 U.S.C. 1396r-4) is amended by adding at  
23          the end the following new subsection:

24          “(h) REDUCTION IN FEDERAL FINANCIAL PARTICI-  
25          PATION FOR DISPROPORTIONATE SHARE ADJUST-



1 MENTS.—Notwithstanding any other provision of this sec-  
2 tion, the amount of payments under section 1903(a) with  
3 respect to any payment adjustment made under this sec-  
4 tion for hospitals in a State for quarters in a fiscal year  
5 shall not exceed the following percent of the amount other-  
6 wise determined under subsection (f):

7           “(1) For fiscal years 1995, 1996, 1997 and  
8           1998, 75 percent.

9           “(2) For fiscal years 1999 and 2000, 70 per-  
10          cent.

11          “(3) For fiscal years 2001 and 2002, 65 per-  
12          cent.

13          “(4) For fiscal year 2003 and thereafter, 63  
14          percent.”.

15          (b) CONFORMING AMENDMENT.—Section 1923(c) of  
16 such Act (42 U.S.C. 1396r-4(c)) is amended in the matter  
17 preceding paragraph (1) by striking “(f) and (g)” and in-  
18 serting “(f), (g), and (h)”.

19          (c) EFFECTIVE DATE.—The amendments made by  
20 subsections (a) and (b) shall apply to quarters in fiscal  
21 years beginning on or after October 1, 1994.

22 **SEC. 3302. ELIMINATION OF MEDICALLY NEEDY PROGRAM**  
23 **FOR INDIVIDUALS NOT IN AN INSTITUTION.**

24          (a) IN GENERAL.—Section 1902(a)(10)(C) of the So-  
25 cial Security Act (42 U.S.C. 1396a(a)(10)(C)) is amended

1 by inserting “such assistance is restricted to individuals  
2 in institutions and” after “, then”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to calendar quarters beginning  
5 on or after January 1, 1998.

6 **SEC. 3303. ELIMINATION OF MEDICAID PEDIATRIC IMMUNI-**  
7 **ZATION PROGRAM.**

8 (a) IN GENERAL.—Effective as if included in the en-  
9 actment of the 13621 of the Omnibus Budget Reconcili-  
10 ation Act of 1993, title XIX of the Social Security Act  
11 is amended as follows:

12 (1) Section 1902(a) (42 U.S.C. 1396a(a)) is  
13 amended—

14 (A) by inserting “and” at the end of para-  
15 graph (60),

16 (B) in paragraph (61), by striking “; and”  
17 and inserting a period, and

18 (C) by striking paragraph (62).

19 (2) Section 1928 (42 U.S.C. 1396s) is repealed.

20 (3) Section 1903(i) (42 U.S.C. 1396b(i)) is  
21 amended—

22 (A) by inserting “or” at the end of para-  
23 graph (12),

24 (B) by striking the semicolon at the end of  
25 paragraph (13) and inserting a period, and

1 (C) by striking paragraphs (14) and (15).

2 (4) Section 1902(a)(32)(D) is amended by  
3 striking “before October 1, 1994”.

4 (5) Section 1902(a) (42 U.S.C. 1396a(a)) is  
5 amended—

6 (A) in paragraph (11)(B)—

7 (i) by inserting “and” before “(ii)”,  
8 and

9 (ii) by striking “to the individual  
10 under section 1903, and (iii) providing for  
11 coordination of information and education  
12 on pediatric vaccinations and delivery of  
13 immunization services” and inserting “to  
14 him under section 1903”;

15 (B) in paragraph (11)(C), by striking “,  
16 including the provision of information and edu-  
17 cation on pediatric vaccinations and the delivery  
18 of immunization services,” and

19 (C) in paragraph (43)(A), by striking “and  
20 the need for age-appropriate immunizations  
21 against vaccine-preventable diseases”.

22 (6) Section 1905(r)(1) (42 U.S.C. 1396d(r)(1))  
23 is amended—

24 (A) in subparagraph (A)(i), by striking  
25 “and, with respect to immunizations under sub-

1 paragraph (B)(iii), in accordance with the  
2 schedule referred to in section 1928(c)(2)(B)(i)  
3 for pediatric vaccines”; and

4 (B) in subparagraph (B)(iii), by striking  
5 “(according to the schedule referred to in sec-  
6 tion 1928(c)(2)(B)(i) for pediatric vaccines)”.

7 (b) ESTABLISHMENT OF ALTERNATIVE DELIVERY  
8 PROGRAMS.—

9 (1) IN GENERAL.—At the request of a State,  
10 the Secretary of Health and Human Services shall  
11 negotiate and enter into contracts with manufactur-  
12 ers of listed pediatric vaccines (which manufacturers  
13 have entered into agreements under section  
14 1902(a)(32)(D) of the Social Security Act) or with  
15 other licensed distributors of such vaccines to pro-  
16 vide for the delivery of such vaccines under a re-  
17 placement vaccine delivery program described in sec-  
18 tion 1902(a)(32)(D) of the Social Security Act or  
19 under an alternative delivery program described in  
20 paragraph (2).

21 (2) ALTERNATIVE DELIVERY PROGRAM.—An al-  
22 ternative delivery program described in this para-  
23 graph is a program operated by a State under which  
24 listed pediatric vaccines are distributed through the  
25 manufacturer (or other licensed distributor) to indi-

1       viduals and entities providing such vaccines under  
2       the State plan under title XIX of the Social Security  
3       Act and other providers of vaccines to children who  
4       are in families eligible for premium assistance under  
5       part A of title XXI of such Act if the providers are  
6       registered to participate in the program and if the  
7       State demonstrates that the operation of the pro-  
8       gram under this paragraph will not result in greater  
9       delivery costs or additional purchases of vaccine  
10      than would have resulted under the program de-  
11      scribed in section 1902(a)(32)(D) of such Act.

12           (3) LISTED PEDIATRIC VACCINE.—In this sub-  
13      section, the term “listed pediatric vaccine” means a  
14      pediatric vaccine contained on the list established  
15      (and periodically reviewed and as appropriate re-  
16      vised) by the Advisory Committee on Immunization  
17      Practices (an advisory committee established by the  
18      Secretary, acting through the Director of the Cen-  
19      ters for Disease Control and Prevention).

20           (4) LIMITATION ON PAYMENT.—Section 1903(i)  
21      of the Social Security Act (42 U.S.C. 1396b(i)), as  
22      amended by subsection (a)(3) and section 2002(b),  
23      is amended—

24                   (A) by striking “or” at the end of para-  
25                   graph (13),

1 (B) by striking the period at the end of  
 2 paragraph (14) and inserting “; or”, and

3 (C) by inserting after paragraph (14) the  
 4 following:

5 “(15) with respect to amounts expended for a  
 6 listed pediatric vaccine (as defined in paragraph (3)  
 7 of section 3303(b) of the Bipartisan Health Care  
 8 Reform Act of 1994) if the amounts exceed the ap-  
 9 plicable price negotiated under a contract entered  
 10 into under subsection (b) of such section.”.

## 11 **TITLE IV—ACCESS** 12 **IMPROVEMENTS**

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1     **Subtitle A—Expanding Access in**  
2                     **Underserved Areas**

3     **SEC. 4001. COMMUNITY HEALTH AUTHORITIES DEM-**  
4                     **ONSTRATION PROJECTS.**

5             (a) IN GENERAL.—Title XIX of the Social Security  
6 Act, as amended by sections 3001(a) and 3201(a)(2), is  
7 amended—

8                 (1) by redesignating section 1933 as section  
9             1934; and

10                (2) by inserting after section 1932 the following  
11             new section:

12             “COMMUNITY HEALTH AUTHORITIES DEMONSTRATION  
13                             PROJECTS

14             “SEC. 1933. (a) IN GENERAL.—In order to test the  
15 effectiveness of various innovative health care delivery ap-  
16 proaches through the operation of community health au-  
17 thorities, the Secretary shall operate a program under  
18 which States establish projects to demonstrate the effec-  
19 tiveness of such approaches in providing access to cost-  
20 effective preventive and primary care and related services  
21 for various areas and populations, including low-income  
22 residents of medically underserved areas or for medically  
23 underserved populations. A State may operate more than  
24 one such project.

25             “(b) SELECTION OF STATE PROJECTS.—



1           “(1) IN GENERAL.—A State is eligible to par-  
2       ticipate in the program, and establish a demonstra-  
3       tion project, under this section only if—

4           “(A) the State submits to the Secretary an  
5       application, at such time and in such form as  
6       the Secretary may require, for participation in  
7       the program; and

8           “(B) the Secretary finds that—

9           “(i) the application contains assur-  
10      ances that the State will support the devel-  
11      opment of a community health authority  
12      that meets the requirements of this sec-  
13      tion,

14          “(ii) the community health authority  
15      will meet the requirements for such an au-  
16      thority under subsection (c),

17          “(iii) the State provides sufficient as-  
18      surances that the demonstration project of  
19      a community health authority meets (or,  
20      when operational, will meet) the require-  
21      ments of subsection (d), and

22          “(iv) the State will comply with the  
23      requirements of subsections (g) and (h).

24           “(2) CONTENTS OF APPLICATION.—Each appli-  
25      cation submitted under paragraph (1) for a dem-

1 demonstration project shall include at least the follow-  
2 ing:

3 “(A) A description of the proposed commu-  
4 nity health authority and of the area or popu-  
5 lation that the authority will serve.

6 “(B) A demonstration that the CHA will  
7 serve at least one geographic area or population  
8 group that is designated as medically under-  
9 served under section 330 of the Public Health  
10 Service Act or as having a shortage of health  
11 professionals under section 332 of such Act.

12 “(C) An assessment of the area’s or popu-  
13 lation’s need for services and an assurance that  
14 the services of the CHA will be responsive to  
15 those needs.

16 “(D) A list of the items and services to be  
17 furnished by the CHA under the project, bro-  
18 ken down by those items and services that are  
19 treated as medical assistance under the State  
20 plan under this title and other items and serv-  
21 ices that will be provided by the CHA (either  
22 directly or through coordination with other  
23 entities).

24 “(E) An assurance that the CHA has en-  
25 tered into (or plans to enter into) written par-

1           ticipation agreements with a sufficient number  
2           of providers to enable the CHA to furnish all of  
3           such items and services to enrolled individuals.

4           “(F) An assurance that the State plan  
5           under this title will provide payment to the au-  
6           thority in accordance with subsection (e).

7           “(G) Evidence of support and assistance  
8           from other State agencies with responsibility for  
9           providing or supporting the provision of preven-  
10          tive and primary care services to underserved  
11          and at-risk populations.

12          “(H) A proposed budget for the CHA.

13          “(3) PERIOD OF APPROVAL.—Each project ap-  
14          proved under this section shall be approved for a pe-  
15          riod of not less than 3 years, subject to renewal for  
16          subsequent periods unless such approval is with-  
17          drawn for cause by the Secretary or at the request  
18          of the State.

19          “(c) COMMUNITY HEALTH AUTHORITY (CHA) DE-  
20          FINED.—In this section, the terms ‘community health au-  
21          thority’ and ‘CHA’ mean a nonprofit entity that meets the  
22          following requirements:

23                 “(1) The entity serves (or will serve at the time  
24                 it becomes operational under a project) a geographic

1 area or population group that includes those  
2 designated—

3 “(A) under section 330 of the Public  
4 Health Service Act as medically underserved, or  
5 “(B) under section 332 of such Act as a  
6 health professions shortage area.

7 “(2) The entity enrolls—

8 “(A) individuals and families who are med-  
9 icaid-eligible;

10 “(B) within the limits of its available re-  
11 sources and capacity, other individuals who  
12 have incomes below 200 percent of the Federal  
13 official poverty level; and

14 “(C) within the limits of its available re-  
15 sources and capacity, other individuals and  
16 families who are able to pay the costs of enroll-  
17 ment.

18 “(3) Through its participating providers, the  
19 entity provides or, through contracts, arranges for  
20 the provision of (or, by the time it become oper-  
21 ational, will so provide or arrange for the provision  
22 of) at least preventive services, primary care serv-  
23 ices, inpatient and outpatient hospital services, and  
24 any other service provided by a participating pro-

1 vider for which payment may be made under the  
2 State plan under this title to enrolled individuals.

3 “(4) The entity must include (to the maximum  
4 extent practicable) as participating providers any of  
5 the following providers that furnish services provided  
6 by (or arranged by) the entity that are located in or  
7 serve the area or population to be covered:

8 “(A) Federally-qualified health centers.

9 “(B) Rural health clinics.

10 “(C) Local public health agencies that fur-  
11 nish such services.

12 “(D) A hospital (or other provider of inpa-  
13 tient or outpatient hospital services) which has  
14 a participation agreement in effect with the  
15 State under its plan under this title, which is  
16 located in or serving the area or population to  
17 be served.

18 “(5) The entity may include as participating  
19 providers other providers (which may include private  
20 physicians or group practice offices, other commu-  
21 nity clinics, limited service providers (such as pre-  
22 natal clinics), and health professionals teaching pro-  
23 grams (such as area health educational centers))  
24 and take other appropriate steps, to the extent need-  
25 ed to assure that the network is reasonable in size

1       and able to provide (or arrange for the provision of)  
2       the services it proposes to furnish to its enrollees.

3           “(6) The entity must maintain written agree-  
4       ments with each participating provider under which  
5       the provider agrees to participate in the CHA and  
6       agrees to accept payment from the CHA as payment  
7       in full for services furnished to individuals enrolled  
8       with the CHA.

9           “(7) Under the written agreements described in  
10      paragraph (6), if a majority of the board of directors  
11      of the entity has determined that a participating  
12      provider is failing to meet any of the requirements  
13      of the participation agreement, the board may termi-  
14      nate the provider’s participation agreement in ac-  
15      cordance with the following requirements:

16           “(A) Subject to subparagraph (B), prior to  
17      any termination of a provider’s participation  
18      agreement, the provider shall be entitled to 30  
19      days prior notice, a reasonable opportunity to  
20      correct any deficiencies, and an opportunity for  
21      a full and fair hearing conducted by the entity  
22      to dispute the reasons for termination. The pro-  
23      vider shall be entitled to appeal the board of di-  
24      rectors’ decision directly to a committee consist-

1       ing of representatives of all of the entity's par-  
2       ticipating providers.

3               “(B) If a majority of the board of directors  
4       of the entity determines that the continued par-  
5       ticipation of a provider presents an immediate  
6       threat to the health and safety of patients or a  
7       substantial risk of improper diversion of funds,  
8       the board may suspend the provider's participa-  
9       tion agreement (including the receipt of funds  
10      under the agreement) for a period of up to 60  
11      days. During this period, the entity shall take  
12      steps to ensure that patients who were assigned  
13      to or cared for by the suspended provider are  
14      appropriately assigned or referred to alternative  
15      participating providers. The suspended provider  
16      shall be entitled to a hearing within the period  
17      of the suspension to show cause why the sus-  
18      pension should be lifted and its participation  
19      agreement restored. If dissatisfied with the  
20      board's decision, the provider shall be entitled  
21      to appeal the decision directly to a committee  
22      consisting of representatives of all of the enti-  
23      ty's participating providers.

24               “(C) For all other disputes between the en-  
25      tity and its participating providers (including

1           disputes over the amounts due or interim rates  
2           to be paid to a provider), the entity shall pro-  
3           vide an opportunity for a full and fair hearing.

4           “(8) The entity must be governed by a board of  
5           directors that includes representatives of the partici-  
6           pating providers and, as appropriate, other health  
7           professionals, civic or business leaders, elected offi-  
8           cials, and residents of the area or population served.  
9           Not less than 51 percent of such board shall be com-  
10          posed of individuals who are enrolled in the CHA  
11          and who are representatives of the community  
12          served.

13          “(d) DEMONSTRATION PROJECT REQUIREMENTS.—  
14          The requirements of this subsection, with respect to a  
15          demonstration project of a CHA under this section, are  
16          as follows:

17               “(1)(A) All services furnished by the CHA  
18               under the project shall be available and accessible to  
19               all enrolled individuals and, except as provided in  
20               subparagraph (B), must be available without regard  
21               to an individual’s ability to pay for such services.

22               “(B) A CHA shall prepare a schedule of dis-  
23               counts to be applied to the payment of premiums by  
24               individuals who are not medicaid-eligible individuals



1       which shall be adjusted on the basis of the individ-  
2       ual's ability to pay.

3           “(2) The CHA shall take appropriate steps to  
4       emphasize the provision of preventive and primary  
5       care services, and shall ensure that each enrolled in-  
6       dividual is assigned to a primary care physician (to  
7       the greatest extent appropriate and feasible), except  
8       that the CHA shall establish a process through  
9       which an enrolled individual may be assigned to an-  
10      other primary care physician for good cause shown.

11          “(3) The CHA must make reasonable efforts to  
12      reduce the unnecessary or inappropriate use of hos-  
13      pital or other high-cost services through an emphasis  
14      on preventive and primary care services, the imple-  
15      mentation of utilization review or other appropriate  
16      methods.

17          “(4) The State must regularly provide the CHA  
18      with information on other medical, health, and relat-  
19      ed benefits that may be available to individuals en-  
20      rolled with the CHA under programs other than the  
21      State plan under this title, and the CHA must pro-  
22      vide its enrolled individuals with enrollment informa-  
23      tion and other non-cash assistance to assist them in  
24      obtaining such benefits.

1           “(5) The State and the CHA must meet such  
2           financial standards and requirements and reporting  
3           requirements as the Secretary specifies and must  
4           prepare and submit to the Secretary an annual inde-  
5           pendent financial audit conducted in accordance with  
6           requirements specified by the Secretary.

7           “(6) In collaboration with the State, the CHA  
8           must adopt and use community-oriented, patient-re-  
9           sponsive quality assurance and control systems in  
10          accordance with requirements specified by the Sec-  
11          retary. Such systems must include at least an ongo-  
12          ing quality assurance program that measures  
13          consumer satisfaction with the care provided under  
14          the network, stresses improved health outcomes, and  
15          operates a community health status improvement  
16          process that identifies and investigates community  
17          health problems and implements measures designed  
18          to remedy them.

19          “(e) CAPITATION PAYMENTS.—

20                 “(1) IN GENERAL.—Under a demonstration  
21          project under this section, the State shall enter into  
22          an annual contract with the CHA under which the  
23          State shall make monthly payments to the CHA for  
24          covered services furnished through the CHA to indi-  
25          viduals entitled to medical assistance under this title

1 in the amount specified in paragraph (2). Payment  
2 shall be made at the beginning of each month on the  
3 basis of estimates of the amounts payable and  
4 amounts subsequently paid are subject to adjust-  
5 ment to reflect the amounts by which previous pay-  
6 ments were greater or less than the amount of pay-  
7 ments that should have been made.

8 “(2) AMOUNT OF CAPITATION PAYMENT.—The  
9 amount of a monthly payment under paragraph (1)  
10 during a contract year, shall be not less than  $\frac{1}{12}$  of  
11 the product of—

12 “(A)(i) the average per capita amounts ex-  
13 pended under this title under the State plan for  
14 covered services to be furnished under the dem-  
15 onstration project for similar Medicaid-eligible  
16 individuals for the most recent 12-month period  
17 ending before the date of the enactment of this  
18 section, increased by (ii) the percentage change  
19 in the consumer price index for all urban con-  
20 sumers (all items; U.S. city average) during the  
21 period that begins upon the expiration of such  
22 12-month period and ends upon the expiration  
23 of the most recent 12-month period ending be-  
24 fore the first month of the contract year for

1           which complete financial data on such index is  
2           available, and

3           “(B) the number of Medicaid-eligible indi-  
4           viduals enrolled under the project as of the  
5           15th day of the month prior to the first month  
6           of the contract year (or, in the case of the first  
7           year for which a contract is in effect under this  
8           subsection, the CHA’s reasonable estimate of  
9           the number of such individuals who will be en-  
10          rolled in the project as of the 15th day of such  
11          month).

12          “(f) ADDITIONAL STATE ASSISTANCE FOR PLAN-  
13          NING, DEVELOPMENT, AND OPERATIONS.—

14               “(1) IN GENERAL.—Subject to paragraph (2),  
15          in addition to the payments under subsection (e),  
16          demonstration projects approved under this section  
17          are eligible to have approved expenditures described  
18          in paragraph (3) treated, for purposes of section  
19          1903(a)(7), as expenditures found necessary by the  
20          Secretary for the proper and efficient administration  
21          of the State plan under this title.

1 “(2) SPECIAL RULES.—

2 “(A) LIMITATION WITH RESPECT TO ANY  
3 COMMUNITY HEALTH AUTHORITY.—The total  
4 amount of expenditures with respect to any  
5 CHA that may be treated as expenditures for  
6 medical assistance under paragraph (1) for any  
7 12-month period shall not exceed \$250,000.

8 “(B) LIMITATION ON NUMBER OF  
9 YEARS.—The number of 12-month periods for  
10 which expenditures are treated as expenditures  
11 for medical assistance under paragraph (1) for  
12 a CHA shall not exceed—

13 “(i) 2 for expenditures for planning  
14 and development assistance, described in  
15 paragraph (3)(A), and

16 “(ii) 2 for expenditures for oper-  
17 ational assistance, described in paragraph  
18 (3)(B).

19 “(C) NO RESULTING REDUCTION IN  
20 AMOUNTS PROVIDED UNDER PHSA GRANTS.—  
21 No grant to a CHA or one of its participating  
22 providers under the Public Health Service Act  
23 or this Act may be reduced on the ground that  
24 activities of the CHA that are considered ap-  
25 proved expenditures under paragraph (3) are

1 activities for which the CHA or the participat-  
2 ing providers received funds under such Act.

3 “(3) APPROVED EXPENDITURES.—The ap-  
4 proved expenditures described in this paragraph are  
5 as follows:

6 “(A) PLANNING AND DEVELOPMENT.—Ex-  
7 penditures for planning and development with  
8 respect to a CHA, including—

9 “(i) developing internal management,  
10 legal and financial and clinical, informa-  
11 tion, and reporting systems for the CHA,  
12 and carrying out other operating activities  
13 of the CHA;

14 “(ii) recruiting, training and com-  
15 pensating management staff of the CHA  
16 and, as appropriate and necessary, man-  
17 agement and clinical staff of any partici-  
18 pating provider;

19 “(iii) purchasing essential equipment  
20 and acquiring, modernizing, expanding, or  
21 (if cost-effective) renovating facilities for  
22 the CHA and for participating providers  
23 (including amortization costs and payment  
24 of interest on loans); and

1           “(iv) entering into arrangements to  
2           obtain or participate in emerging medical  
3           technologies, including telemedicine.

4           “(B) OPERATIONS.—Expenditures in sup-  
5           port of the operations of a CHA, including—

6                   “(i) the ongoing management of the  
7                   CHA, including daily program administra-  
8                   tion, recordkeeping and reporting, assur-  
9                   ance of proper financial management (in-  
10                  cluding billings and collections) and over-  
11                  sight of program quality;

12                   “(ii) developing and operating systems  
13                  to enroll eligible individuals in the CHA;

14                   “(iii) data collection, in collaboration  
15                  with the State medicaid agency and the  
16                  State health department, designed to  
17                  measure changes in patient access to care,  
18                  the quality of care furnished, and patient  
19                  health status, and health care outcomes;

20                   “(iv) ongoing community outreach  
21                  and community education to all residents  
22                  of the area or population served, to pro-  
23                  mote the enrollment of eligible individuals  
24                  and the appropriate utilization of health  
25                  services by such individuals;

1           “(v) the establishment of necessary  
2           reserves or purchase of stop-loss coverage;  
3           and

4           “(vi) activities relating to health pro-  
5           fessions training, including residency train-  
6           ing at participating provider sites.

7           “(g) ADDITIONAL REQUIREMENTS.—

8           “(1) MANDATORY ENROLLMENT OF MEDICAID-  
9           ELIGIBLE INDIVIDUALS.—Notwithstanding any pro-  
10          vision of section 1903(m), a State participating in a  
11          demonstration project under this section may, until  
12          December 31, 1997, require that each medicaid-eli-  
13          gible resident in the service area of a CHA operating  
14          under the project is not eligible to receive any medi-  
15          cal assistance under the State plan that may be ob-  
16          tained through enrollment with the CHA unless the  
17          individual receives such assistance through enroll-  
18          ment with the CHA.

19          “(2) CONTINUED ENTITLEMENT TO ADDI-  
20          TIONAL BENEFITS.—In the case of a medicaid-eli-  
21          gible individual enrolled with a CHA under a dem-  
22          onstration project under this section, the individual  
23          shall remain entitled to medical assistance for serv-  
24          ices which are not covered services under the project,  
25          until December 31, 1997.



1           “(3) HMO-RELATED REQUIREMENTS.—A CHA  
2           under this section shall be deemed to meet the re-  
3           quirements of section 1903(m) (subject to paragraph  
4           (1)) in the same manner as an entity listed under  
5           section 1903(m)(2)(G).

6           “(4) OUTSTATIONING ELIGIBILITY WORKERS.—  
7           Under the project, the State may (in addition to  
8           meeting the requirements of section 1902(a)(55)  
9           until December 31, 1997) provide for, or pay the  
10          reasonable costs of, stationing eligibility workers at  
11          appropriate service sites under the project, and may  
12          permit medicaid-eligible individuals to be enrolled  
13          under the State plan at such a CHA or at such a  
14          site.

15          “(5) PURCHASE OF STOP-LOSS COVERAGE.—  
16          The State shall ensure that the CHA has purchased  
17          stop-loss coverage to protect against default on its  
18          obligations under the project. If an entity otherwise  
19          qualified to serve as a CHA is prohibited under  
20          State law from purchasing such coverage, the State  
21          shall waive the application of such law to the extent  
22          necessary to permit the entity to purchase such cov-  
23          erage.

24          “(h) EVALUATION AND REPORTING.—

1           “(1) CHA.—Each CHA in a State with a dem-  
2           onstration project approved under this section shall  
3           prepare and submit to the State an annual report on  
4           its activities during the previous year.

5           “(2) STATE.—Taking into account the reports  
6           submitted pursuant to paragraph (1), each State  
7           with a demonstration project approved under this  
8           section shall prepare and submit to the Secretary an  
9           annual evaluation of its activities and services under  
10          this section. Such evaluation shall include an analy-  
11          sis of the effectiveness of the project in providing  
12          cost-effective health care to enrolled individuals.

13          “(3) REPORT TO CONGRESS.—Not later than  
14          June 30, 1997, the Secretary shall submit to Con-  
15          gress a report on the demonstration projects con-  
16          ducted under this section. Such report shall include  
17          an analysis of the effectiveness of such projects in  
18          providing cost-effective health care for the areas or  
19          populations served.

20          “(i) COLLABORATION IN ADMINISTRATION.—In car-  
21          rying out this section, the Secretary shall assure the high-  
22          est possible level of collaboration between the Health Care  
23          Financing Administration and the Public Health Service.  
24          Such collaboration may include (if appropriate and fea-  
25          sible) any of the following:

1           “(1) The provision by the Public Health Service  
2 of new or increased grant support to eligible entities  
3 participating in a CHA, in order to expand the avail-  
4 ability of services (particularly preventive and pri-  
5 mary care services).

6           “(2) The placement of health professionals at  
7 eligible locations and collaboration with Federally-  
8 assisted health professions training programs located  
9 in or near the areas served by community health  
10 authorities.

11           “(3) The provision of technical and other non-  
12 financial assistance.

13           “(j) DEFINITIONS.—In this section:

14           “(1) MEDICAID-ELIGIBLE INDIVIDUAL.—The  
15 term ‘medicaid-eligible individual’ means an individ-  
16 ual described in section 1902(a)(10)(A) and entitled  
17 to medical assistance under the State plan.

18           “(2) PARTICIPATING PROVIDER.—The term  
19 ‘participating provider’ means, with respect to a  
20 CHA, a provider that has entered into an agreement  
21 with the CHA for the provision of covered services  
22 under a project under this section.

23           “(3) PREVENTIVE AND PRIMARY CARE SERV-  
24 ICES.—‘Preventive’ and ‘primary’ services include  
25 those services described in section 1905(l)(2)(A) and

1 included as Federally qualified health center  
2 services.”.

3 (b) EXCEPTION TO ANTI-KICKBACK LAW.—Section  
4 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is  
5 amended—

6 (1) by striking “and” at the end of subpara-  
7 graph (D),

8 (2) by striking the period at the end of sub-  
9 paragraph (E) and inserting “; and”, and

10 (3) by adding at the end the following new sub-  
11 paragraph:

12 “(F) any remuneration paid, or received,  
13 by a Federally qualified health center, rural  
14 health clinic, or other entity which is a partici-  
15 pating provider under a demonstration project  
16 under section 1933 as part of an arrangement  
17 for the procurement of goods or services or the  
18 referral of patients or the lease or purchase of  
19 space or equipment.”.

20 (c) TRANSITION.—A premium subsidy eligible indi-  
21 vidual may use premium assistance certificates issued  
22 under title XXI of the Social Security Act to purchase  
23 qualified health coverage offered by a community health  
24 authority that complies with the requirements for a carrier  
25 under title I.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall take effect on the date of the enactment  
3 of this Act.

4 **SEC. 4002. HEALTH CENTER PROGRAM AMENDMENTS.**

5 (a) AUTHORIZATION OF GRANTS FOR NETWORK DE-  
6 VELOPMENT.—

7 (1) MIGRANT HEALTH CENTERS.—

8 (A) IN GENERAL.—Section 329 of the  
9 Public Health Service Act (42 U.S.C. 254b) is  
10 amended by adding at the end the following:

11 “(j)(1) The Secretary may make a grant, to an entity  
12 receiving a grant under this section or to a group of such  
13 entities, to support the planning and development of  
14 health service networks (as defined in paragraph (3))  
15 which will serve high impact areas, medically underserved  
16 areas, or medically underserved populations within the  
17 area they serve (or propose to serve).

18 “(2) A grant under this subsection for the planning  
19 and development of a health service network may be used  
20 for the following costs:

21 “(A) The costs of developing the network cor-  
22 porate entity, including planning and needs assess-  
23 ment.

24 “(B) The costs of developing internal manage-  
25 ment for the network, as well as costs of developing

1 legal, financial, clinical, information, billing, and re-  
2 porting systems, and other costs necessary to  
3 achieve operational status.

4 “(C) The costs of recruitment, training, and  
5 compensation of management staff of the network  
6 and, as appropriate and necessary, the management  
7 and clinical staff of any participating provider.

8 “(D) The costs of developing additional primary  
9 health and related service sites, including costs relat-  
10 ed to purchase of essential equipment, acquisition,  
11 modernization, expansion, or, if cost-effective, con-  
12 struction of facilities.

13 “(3) In this subsection, the term ‘health service net-  
14 work’ means a nonprofit private entity that—

15 “(A) through its participating providers (which  
16 may provide services directly or through contract)  
17 assures the provision of primary health and related  
18 services and, as appropriate, supplemental health  
19 services to residents of the high impact area or  
20 medically underserved area or members of the medi-  
21 cally underserved population covered by the network,

22 “(B) includes, as participating providers, at  
23 least all recipients of grants under this section or  
24 section 330, 340, or 340A that provide primary  
25 health and related services to the residents of the

1 area it serves (or proposes to serve), and that may  
2 include, at the entity's option, any other providers of  
3 primary health or supplemental health services to  
4 residents of the high impact area or medically un-  
5 derserved area or members of the medically under-  
6 served population covered by the network, but only  
7 if such participating providers agree to provide serv-  
8 ices without regard to an individual's ability to pay,  
9 and

10 “(C) is governed by individuals a majority of  
11 whom are patients, employees, or board members of  
12 its participating providers that receive grants under  
13 this section or section 330, 340, or 340A.”.

14 (B) CONFORMING CHANGE.—Section  
15 329(h)(1)(A) of such Act (42 U.S.C.  
16 254b(h)(1)(A)) is amended by inserting “and  
17 subsection (j)” after “through (e)”.

18 (2) COMMUNITY HEALTH CENTERS.—Section  
19 330 of such Act (42 U.S.C. 254c) is amended by  
20 adding at the end the following:

21 “(l)(1) The Secretary may make a grant, to an entity  
22 receiving a grant under this section or to a group of such  
23 entities, to support the planning and development of  
24 health service networks (as defined in section 329(j)(3))  
25 which will serve high impact areas, medically underserved

1 areas, or medically underserved populations within the  
2 area they serve (or propose to serve).

3 “(2) A grant under this subsection for the planning  
4 and development of a health service network may be used  
5 for the costs described in section 329(j)(2).”.

6 (3) EFFECTIVE DATE.—The amendments made  
7 by this subsection shall take effect on the date of the  
8 enactment of this Act.

9 (b) REGULATIONS DEFINING MEDICALLY UNDER-  
10 SERVED POPULATIONS AND FRONTIER AREAS.—Within 1  
11 year after the date of the enactment of this Act, the Sec-  
12 retary of Health and Human Services shall promulgate  
13 regulations that define medically underserved populations  
14 and frontier areas for purposes of title III of the Public  
15 Health Service Act.

16 (c) EXTENSION OF AUTHORIZATION OF APPROPRIA-  
17 TIONS.—For extension of authorization of appropriations  
18 for migrant health centers and community health centers,  
19 see section 4131.



1       **Subtitle B—Improved Access in**  
2                   **Rural Areas**

3       **PART 1—GRANTS TO ENCOURAGE COMMUNITY**  
4                   **RURAL HEALTH NETWORKS**

5       **SEC. 4101. ASSISTANCE FOR DEVELOPMENT OF ACCESS**  
6                   **PLANS FOR CHRONICALLY UNDERSERVED**  
7                   **AREAS.**

8           (a) AVAILABILITY OF FINANCIAL ASSISTANCE TO IM-  
9       PLEMENT ACTION PLANS TO INCREASE ACCESS.—

10           (1) IN GENERAL.—The Secretary shall provide  
11       grants (in amounts determined in accordance with  
12       paragraph (3)) over a 3-year period to an eligible  
13       State for the development of plans to increase access  
14       to health care services during such period for resi-  
15       dents of areas in the State that are designated as  
16       chronically underserved areas in accordance with  
17       subsection (b).

18           (2) ELIGIBILITY REQUIREMENTS.—A State is  
19       eligible to receive grants under this section if the  
20       State submits to the Secretary (at such time and in  
21       such form as the Secretary may require) assurances  
22       that the State has developed (or is in the process of  
23       developing) a plan to increase the access of residents  
24       of a chronically underserved area to health care serv-  
25       ices that meets the requirements of subsection (c),

1 together with such other information and assurances  
2 as the Secretary may require.

3 (3) AMOUNT OF ASSISTANCE.—

4 (A) IN GENERAL.—Subject to subpara-  
5 graph (B), the amount of assistance provided to  
6 a State under this subsection with respect to  
7 any plan during a 3-year period shall be equal  
8 to—

9 (i) for the first year of the period, an  
10 amount equal to 100 percent of the  
11 amounts expended by the State during the  
12 year to implement the plan described in  
13 paragraph (1) (as reported to the Sec-  
14 retary in accordance with such require-  
15 ments as the Secretary may impose);

16 (ii) for the second year of the period,  
17 an amount equal to 50 percent of the  
18 amounts expended by the State during the  
19 year to implement the plan; and

20 (iii) for the third year of the period,  
21 an amount equal to 33 percent of the  
22 amounts expended by the State during the  
23 year to implement the plan.

24 (B) AGGREGATE PER PLAN LIMIT.—The  
25 amount of assistance provided to a State under

1           this subsection with respect to any plan may  
2           not exceed \$100,000 during any year of the 3-  
3           year period for which the State receives assist-  
4           ance.

5       (b) DESIGNATION OF AREAS.—

6           (1) DESIGNATION BY GOVERNOR.—In accord-  
7           ance with the guidelines developed under paragraph  
8           (2), the Governor of a State may designate an area  
9           in the State as a chronically underserved area for  
10          purposes of this section upon the request of a local  
11          official of the area or upon the Governor’s initiative.

12          (2) GUIDELINES FOR DESIGNATION.—

13           (A) DEVELOPMENT BY SECRETARY.—Not  
14           later than 1 year after the date of the enact-  
15           ment of this Act, the Secretary shall develop  
16           guidelines for the designation of areas as chron-  
17           ically underserved areas under this section.

18           (B) FACTORS CONSIDERED IN DEVELOP-  
19           MENT OF GUIDELINES.—In developing guide-  
20           lines under paragraph (1), the Secretary shall  
21           consider the following factors:

22                   (i) Whether the area (or a significant  
23                   portion of the area)—

24                           (I) is designated as a health pro-  
25                           fessional shortage area (under section

1           332(a) of the Public Health Service  
2           Act), or meets the criteria for des-  
3           ignation as such an area; or

4                     (II) was previously designated as  
5           such an area or previously met such  
6           criteria for an extended period prior  
7           to the designation of the area under  
8           this section (in accordance with cri-  
9           teria established by the Secretary).

10                   (ii) The availability and adequacy of  
11           health care providers and facilities for resi-  
12           dents of the area.

13                   (iii) The extent to which the availabil-  
14           ity of assistance under other Federal and  
15           State programs has failed to alleviate the  
16           lack of access to health care services for  
17           residents of the area.

18                   (iv) The percentage of residents of the  
19           area whose income is at or below the pov-  
20           erty level.

21                   (v) The percentage of residents of the  
22           area who are age 65 or older.

23                   (vi) The existence of cultural or geo-  
24           graphic barriers to access to health care

1 services in the area, including weather con-  
2 ditions.

3 (3) REVIEW BY SECRETARY.—No designation  
4 under paragraph (1) shall take effect under this sec-  
5 tion unless the Secretary—

6 (A) has been notified of the proposed des-  
7 ignation; and

8 (B) has not, within 60 days after the date  
9 of receipt of the notice, disapproved the des-  
10 ignation.

11 (4) PERIOD OF DESIGNATION.—A designation  
12 under this section shall be effective during a period  
13 specified by the Governor of not longer than 3 years.  
14 The Governor may extend the designation for addi-  
15 tional 3-year periods, except that a State may not  
16 receive assistance under subsection (a)(3) for  
17 amounts expended during any such additional peri-  
18 ods.

19 (c) REQUIREMENTS FOR STATE ACCESS PLANS.—A  
20 State plan to increase the access of residents of chronically  
21 underserved areas to health care services meets the re-  
22 quirements of this section if the Secretary finds that the  
23 plan was developed with the participation of health care  
24 providers and facilities and residents of the area that is

1 the subject of the plan, together with such other require-  
2 ments as the Secretary may impose.

3 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
4 are authorized to be appropriated for assistance under this  
5 section \$10,000,000 for each of the first 3 fiscal years  
6 beginning after the date on which the Secretary develops  
7 guidelines for the designation of areas as chronically un-  
8 derserved areas under subsection (b)(2).

9 **SEC. 4102. TECHNICAL ASSISTANCE GRANTS FOR NET-**  
10 **WORKS.**

11 (a) IN GENERAL.—The Secretary shall make funds  
12 available under this section to provide technical assistance  
13 (including information regarding eligibility for other Fed-  
14 eral programs) and advice for entities described in sub-  
15 section (b) seeking to establish or enhance a community  
16 rural health network in an underserved rural area.

17 (b) ENTITIES ELIGIBLE TO RECEIVE FUNDS.—The  
18 following entities are eligible to receive funds for technical  
19 assistance under this section:

20 (1) An entity receiving a grant under section  
21 4103.

22 (2) A State or unit of local government.

23 (3) An entity providing health care services (in-  
24 cluding health professional education services) in the  
25 area involved.

1 (c) USE OF FUNDS.—

2 (1) IN GENERAL.—Funds made available under  
3 this section may be used—

4 (A) for planning a community health net-  
5 work and the submission of the plan for the  
6 network to the Secretary under section 4103(c)  
7 (subject to the limitation described in para-  
8 graph (2));

9 (B) to provide assistance in conducting  
10 community-based needs and prioritization, iden-  
11 tifying existing regional health resources, and  
12 developing networks, utilizing existing local pro-  
13 viders and facilities where appropriate;

14 (C) to provide advice on obtaining the  
15 proper balance of primary and secondary facili-  
16 ties for the population served by the network;

17 (D) to provide assistance in coordinating  
18 arrangements for tertiary care;

19 (E) to provide assistance in recruitment  
20 and retention of health care professionals;

21 (F) to provide assistance in coordinating  
22 the delivery of emergency services with the pro-  
23 vision of other health care services in the area  
24 served by the network;

1 (G) to provide assistance in coordinating  
2 arrangements for mental health and substance  
3 abuse treatment services; and

4 (H) to provide information regarding the  
5 area or proposed network's eligibility for Fed-  
6 eral and State assistance for health care-related  
7 activities, together with information on funds  
8 available through private sources.

9 (2) LIMITATION ON AMOUNT AVAILABLE FOR  
10 DEVELOPMENT OF NETWORK.—The amount of fi-  
11 nancial assistance available for activities described in  
12 paragraph (1) may not exceed \$50,000 and may not  
13 be available for a period of time exceeding 1 year.

14 (d) USE OF RURAL HEALTH OFFICES.—In carrying  
15 out this section with respect to entities in rural areas, the  
16 Secretary shall make funds available through—

17 (1) not more than 10 regional centers acting as  
18 clearinghouses for the distribution of such funds;  
19 and

20 (2) State Offices of Rural Health, or any com-  
21 bination of such centers and Offices.

22 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
23 are authorized to be appropriated \$10,000,000 for each  
24 of fiscal years 1996 and 1997 and \$30,000,000 for each  
25 of fiscal years 1998 through 2000 to carry out this sec-



1 tion. Amounts appropriated under this section shall be  
2 available until expended.

3 **SEC. 4103. DEVELOPMENT GRANTS FOR NETWORKS.**

4 (a) IN GENERAL.—The Secretary shall provide finan-  
5 cial assistance to eligible entities in order to provide for  
6 the development and implementation of community rural  
7 health networks.

8 (b) ELIGIBLE ENTITIES.—

9 (1) IN GENERAL.—An entity is eligible to re-  
10 ceive financial assistance under this section only if  
11 the entity—

12 (A) is (i) based in a rural area or (ii) is  
13 described in paragraph (2), (3), or (4) of sec-  
14 tion 4102(b),

15 (B) is undertaking to develop and imple-  
16 ment a community rural health network in an  
17 underserved rural area (or underserved rural  
18 areas) with the active participation of at least  
19 3 health care providers or facilities in the area,  
20 and

21 (C) has consulted with the local govern-  
22 ments of the area to be served by the network  
23 and with individuals who reside in the area.

24 (2) COORDINATION WITH PROVIDERS OUTSIDE  
25 OF AREA PERMITTED.—Nothing in this section shall

1 be construed as preventing an entity that coordi-  
2 nates the delivery of services in an underserved rural  
3 area with an entity outside the area from qualifying  
4 for financial assistance under this section, or as pre-  
5 venting an entity consisting of a consortia of mem-  
6 bers located in adjoining States from qualifying for  
7 such assistance.

8 (3) PERMITTING ENTITIES NOT RECEIVING  
9 FUNDING FOR DEVELOPMENT OF PLAN TO RECEIVE  
10 FUNDING FOR IMPLEMENTATION.—An entity that is  
11 eligible to receive financial assistance under this sec-  
12 tion may receive assistance to carry out activities de-  
13 scribed in subsection (c)(1)(B) notwithstanding that  
14 the entity does not receive assistance to carry out  
15 activities described in subsection (c)(1)(A).

16 (c) USE OF FUNDS.—

17 (1) IN GENERAL.—Financial assistance made  
18 available to eligible entities under this section may  
19 be used only—

20 (A) for the development of a community  
21 health network and the submission of the plan  
22 for the network to the Secretary; and

23 (B) after the Secretary approves the plan  
24 for the network, for activities to implement the  
25 network, including (but not limited to)—

- 1 (i) establishing information systems,  
2 including telecommunications,
- 3 (ii) recruiting health care providers,
- 4 (iii) providing services to enable indi-  
5 viduals to have access to health care serv-  
6 ices, including transportation and language  
7 interpretation services (including interpre-  
8 tation services for the hearing-impaired),  
9 and
- 10 (iv) establishing and operating a com-  
11 munity health advisor program described  
12 in paragraph (2).

13 (2) COMMUNITY HEALTH ADVISOR PROGRAM.—

14 (A) PROGRAM DESCRIBED.—In paragraph  
15 (1), a “community health advisor program” is  
16 a program under which community health advi-  
17 sors carry out the following activities:

- 18 (i) Collaborating efforts with health  
19 care providers and related entities to facili-  
20 tate the provision of health services and  
21 health-related social services.
- 22 (ii) Providing public education on  
23 health promotion and disease prevention  
24 and efforts to facilitate the use of available

1 health services and health-related social  
2 services.

3 (iii) Providing health-related counsel-  
4 ing.

5 (iv) Making referrals for available  
6 health services and health-related social  
7 services.

8 (v) Improving the ability of individ-  
9 uals to use health services and health-  
10 related social services under Federal,  
11 State, and local programs through assist-  
12 ing individuals in establishing eligibility  
13 under the programs.

14 (vi) Providing outreach services to in-  
15 form the community of the availability of  
16 the services provided under the program.

17 (B) COMMUNITY HEALTH ADVISOR DE-  
18 FINED.—In subparagraph (A), the term “com-  
19 munity health advisor” means, with respect to  
20 a community health advisor program, an  
21 individual—

22 (i) who has demonstrated the capacity  
23 to carry out one or more of the activities  
24 carried out under the program; and

1                   (ii) who, for not less than one year,  
2                   has been a resident of the community in  
3                   which the program is to be operated.

4                   (3) LIMITATIONS ON ACTIVITIES FUNDED.—Fi-  
5                   nancial assistance made available under this section  
6                   may not be used for any of the following:

7                   (A) For a telecommunications system un-  
8                   less such system is coordinated with, and does  
9                   not duplicate, a system existing in the area.

10                  (B) For construction or remodeling of  
11                  health care facilities.

12                  (4) LIMITATION ON AMOUNT AVAILABLE FOR  
13                  DEVELOPMENT OF NETWORK.—The amount of fi-  
14                  nancial assistance available for activities described in  
15                  paragraph (1)(A) may not exceed \$50,000 and may  
16                  not be made available for a period of time exceeding  
17                  1 year.

18                  (d) APPLICATION.—

19                  (1) IN GENERAL.—No financial assistance shall  
20                  be provided under this section to an entity unless  
21                  the entity has submitted to the Secretary, in a time  
22                  and manner specified by the Secretary, and had ap-  
23                  proved by the Secretary an application.

24                  (2) INFORMATION TO BE INCLUDED.—Each  
25                  such application shall include—

1           (A) a description of the community rural  
2           health network, including service area and ca-  
3           capacity, and

4           (B) a description of how the proposed net-  
5           work will utilize existing health care facilities in  
6           a manner that avoids unnecessary duplication.

7           (e) AUTHORIZATION OF APPROPRIATIONS.—

8           (1) IN GENERAL.—There are authorized to be  
9           appropriated \$100,000,000 for each of fiscal years  
10          1996 and 1997, \$120,000,000 for fiscal year 1998,  
11          \$130,000,000 for fiscal year 1999, \$140,000,000 for  
12          fiscal year 2000, \$150,000,000 for fiscal year 2001,  
13          \$160,000,000 for fiscal year 2002, \$170,000,000 for  
14          fiscal year 2003, and \$180,000,000 for fiscal year  
15          2004, to carry out this section. Amounts appro-  
16          priated under this section shall be available until ex-  
17          pended.

18          (2) INTEGRATION OF OTHER AUTHORIZA-  
19          TIONS.—In order to provide for the authorization of  
20          appropriations under paragraph (1), notwithstanding  
21          any other provision of law, no funds are authorized  
22          to be appropriated to carry out the following pro-  
23          grams in fiscal years after fiscal year 1994:

1           (A) The rural health transition grant pro-  
2           gram (under section 4005(e) of the Omnibus  
3           Budget Reconciliation Act of 1987).

4           (B) The rural health outreach program  
5           (for which appropriations were annually pro-  
6           vided under the Departments of Labor, Health  
7           and Human Services, and Education, and Re-  
8           lated Agencies Appropriation Acts).

9           (3) ANNUAL LIMIT ON ASSISTANCE TO  
10          GRANTEE.—The amount of financial assistance pro-  
11          vided to an entity under this section during a year  
12          may not exceed \$250,000.

13   **SEC. 4104. DEFINITIONS.**

14          For purposes of this part:

15           (1) COMMUNITY RURAL HEALTH NETWORK.—  
16          The term “community rural health network” means  
17          a formal cooperative arrangement between partici-  
18          pating hospitals, physicians, and other health care  
19          providers which—

20                   (A) is located in an underserved rural  
21                   area;

22                   (B) furnishes health care services to indi-  
23                   viduals residing in the area; and

1           (C) is governed by a board of directors se-  
2           lected by participating health care providers  
3           and residents of the area.

4           (2) RURAL AREA.—The term “rural area” has  
5           the meaning given such term in section  
6           1886(d)(2)(D) of the Social Security Act.

7           (3) SECRETARY.—The term “Secretary” means  
8           the Secretary of Health and Human Services.

9           (4) STATE.—The term “State” means each of  
10          the several States, the District of Columbia, Puerto  
11          Rico, the Virgin Islands, Guam, the Northern Mari-  
12          ana Islands, and American Samoa.

13          (5) UNDERSERVED RURAL AREA.—The term  
14          “underserved rural area” means a rural area des-  
15          ignated—

16                (A) as a health professional shortage area  
17                under section 332(a) of the Public Health Serv-  
18                ice Act; or

19                (B) as a chronically underserved area  
20                under section 4101.



1           **PART 2—INCENTIVES FOR HEALTH**  
2           **PROFESSIONALS TO PRACTICE IN RURAL AREAS**  
3           **Subpart A—National Health Service Corps**  
4                           **Program**

5   **SEC. 4111. NATIONAL HEALTH SERVICE CORPS LOAN RE-**  
6                           **PAYMENTS EXCLUDED FROM GROSS INCOME.**

7           (a) IN GENERAL.—Part III of subchapter B of chap-  
8   ter 1 of the Internal Revenue Code of 1986 (relating to  
9   items specifically excluded from gross income) is amended  
10  by redesignating section 137 as section 138 and by insert-  
11  ing after section 136 the following new section:

12   **“SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN RE-**  
13                           **PAYMENTS.**

14           “(a) GENERAL RULE.—Gross income shall not in-  
15  clude any qualified loan repayment.

16           “(b) QUALIFIED LOAN REPAYMENT.—For purposes  
17  of this section, the term ‘qualified loan repayment’ means  
18  any payment made on behalf of the taxpayer by the Na-  
19  tional Health Service Corps Loan Repayment Program  
20  under section 338B(g) of the Public Health Service Act.”.

21           (b) CONFORMING AMENDMENT.—Paragraph (3) of  
22  section 338B(g) of the Public Health Service Act is  
23  amended by striking “Federal, State, or local” and insert-  
24  ing “State or local”.

25           (c) CLERICAL AMENDMENT.—The table of sections  
26  for part III of subchapter B of chapter 1 of the Internal

1 Revenue Code of 1986 is amended by striking the item  
2 relating to section 137 and inserting the following:

“Sec. 137. National Health Service Corps loan repayments.  
“Sec. 138. Cross references to other Acts.”.

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to payments made under section  
5 338B(g) of the Public Health Service Act after the date  
6 of the enactment of this Act.

7 **SEC. 4112. MODIFICATION IN CRITERIA FOR DESIGNATION**  
8 **AS HEALTH PROFESSIONAL SHORTAGE AREA.**

9 (a) RELEVANCE OF TRAVEL TIMES WITHIN FRON-  
10 TIER AREAS.—Section 332(a) of the Public Health Service  
11 Act (42 U.S.C. 245e(a)) is amended by adding at the end  
12 the following new paragraph:

13 “(4) With respect to meeting the criteria under  
14 paragraph (1)(A) for an area to be designated as a  
15 health professional shortage area, the Secretary  
16 shall, in the case of a frontier area, make the deter-  
17 mination of whether the frontier area is a rational  
18 area for the delivery of health services without re-  
19 gard to—

20 “(A) the travel time between population  
21 centers in the frontier area; or

22 “(B) the travel time to contiguous area re-  
23 sources in the frontier area.”.

1       (b) REGULATIONS DEFINING HEALTH PROFES-  
2       SIONAL SHORTAGE AREAS.—Within 1 year after the date  
3       of the enactment of this Act, the Secretary of Health and  
4       Human Services shall promulgate regulations that define  
5       health professional shortage areas for purposes of title III  
6       of the Public Health Service Act.

7       (c) AGENCY RECOMMENDATIONS FOR IMPROVE-  
8       MENTS.—Not later than July 1, 1995, the Secretary of  
9       Health and Human Services shall submit to the Congress  
10      a report specifying the recommendations of the Secretary  
11      for improving the manner of determining the extent to  
12      which a geographic area has a need for assignments of  
13      members of the National Health Service Corps, and for  
14      equitably allocating such assignments among the geo-  
15      graphic areas with a need for such assignments.

16      (d) EFFECTIVE DATE.—This section shall take effect  
17      on October 1, 1994, or upon the date of the enactment  
18      of this Act, whichever occurs later.

19      **SEC. 4113. OTHER PROVISIONS REGARDING NATIONAL**  
20                                      **HEALTH SERVICE CORPS.**

21      (a) SCHOLARSHIP AND LOAN REPAYMENT PRO-  
22      GRAMS.—

23              (1) AUTHORIZATION OF APPROPRIATIONS.—  
24      Section 338H(b)(1) of the Public Health Service Act  
25      (42 U.S.C. 254q(b)(1)) is amended—

1 (A) by striking “and” after “1991,”; and

2 (B) by striking “through 2000.” and in-  
3 serting “through 1994, \$150,000,000 for fiscal  
4 year 1995, \$175,000,000 for fiscal year 1996,  
5 \$200,000,000 for fiscal year 1997,  
6 \$275,000,000 for fiscal year 1998,  
7 \$275,000,000 for fiscal year 1999,  
8 \$275,000,000 for fiscal year 2000,  
9 \$300,000,000 for fiscal year 2001,  
10 \$325,000,000 for fiscal year 2002,  
11 \$350,000,000 for fiscal year 2003, and  
12 \$375,000,000 for fiscal year 2004.”.

13 (2) ALLOCATION FOR PARTICIPATION OF  
14 NURSES IN SCHOLARSHIP PROGRAM.—Section  
15 338H(b)(2) of the Public Health Service Act (42  
16 U.S.C. 254q(b)(2)) is amended by adding at the end  
17 the following subparagraph:

18 “(C) Of the amounts appropriated under  
19 paragraph (1) for fiscal year 1995 and subse-  
20 quent fiscal years, the Secretary shall reserve  
21 such amounts as may be necessary to ensure  
22 that, of the aggregate number of individuals  
23 who are participants in the Scholarship Pro-  
24 gram, the total number who are being educated

1           as nurses or are serving as nurses, respectively,  
2           is increased to 20 percent.”.

3           (b) INCREASE IN NUMBER OF MENTAL HEALTH  
4 PROFESSIONALS IN SHORTAGE AREAS.—

5           (1) IN GENERAL.—Section 338H(b) of the Pub-  
6 lic Health Service Act (42 U.S.C. 254q(b)) is  
7 amended by adding at the end the following para-  
8 graph:

9           “(3) MENTAL HEALTH PROFESSIONALS.—In  
10 providing contracts under this subpart for scholar-  
11 ships and loan repayments, the Secretary shall en-  
12 sure that an appropriate number of mental health  
13 professionals is assigned under section 333 for  
14 health professional shortage areas.”.

15           (2) APPLICABILITY.—With respect to contracts  
16 for scholarships and loan repayments under subpart  
17 III of part D of title III of the Public Health Service  
18 Act, the amendment made by subsection (a) applies  
19 with respect to contracts entered into on or after Oc-  
20 tober 1, 1994.

1           **Subpart B—Incentives Under Other**  
2                           **Programs**

3   **SEC. 4121. EXTENSION OF ADDITIONAL PAYMENT UNDER**  
4                           **MEDICARE FOR PHYSICIANS' SERVICES FUR-**  
5                           **NISHED IN FORMER SHORTAGE AREAS.**

6           (a) IN GENERAL.—Section 1833(m) of the Social Se-  
7   curity Act (42 U.S.C. 1395l(m)) is amended by striking  
8   “area,” and inserting “area (or, in the case of an area  
9   for which the designation as a health professional shortage  
10   area under such section is withdrawn, in the case of physi-  
11   cians’ services furnished to such an individual during the  
12   3-year period beginning on the effective date of the with-  
13   drawal of such designation),”.

14          (b) EFFECTIVE DATE.—The amendment made by  
15   subsection (a) shall apply to physicians’ services furnished  
16   in an area for which the designation as a health profes-  
17   sional shortage area under section 332(a)(1)(A) of the  
18   Public Health Service Act is withdrawn on or after Janu-  
19   ary 1, 1995.

20   **SEC. 4122. REFINEMENT OF GEOGRAPHIC ADJUSTMENT**  
21                           **FACTOR FOR MEDICARE PHYSICIANS' SERV-**  
22                           **ICES.**

23          (a) DEADLINE FOR INITIAL REVIEW AND REVI-  
24   SION.—Section 1848(e)(1)(C) of the Social Security Act  
25   (42 U.S.C. 1395w-4(e)(1)(C)) is amended by adding at

1 the end the following: “The first such review and revision  
2 shall apply to services furnished on or after January 1,  
3 1995.”.

4 (b) AUTHORITY TO ADJUST INDEX VALUE FOR  
5 INPUT COMPONENT UNDER CERTAIN CIRCUMSTANCES.—

6 (1) Section 1848(e)(1) of the Social Security Act (42  
7 U.S.C. 1395w–4(e)(1)) is amended—

8 (A) in subparagraph (A), by striking “(B) and  
9 (C)” and inserting “(B), (C), and (D)”;

10 (B) by redesignating subparagraph (C) as sub-  
11 paragraph (D); and

12 (C) by inserting after subparagraph (B) the fol-  
13 lowing:

14 “(C) SPECIAL ADJUSTMENT TO CORRECT  
15 FOR UNIQUE LOCAL CIRCUMSTANCES.—The  
16 Secretary may adjust the value assigned to an  
17 input component of an index in a fee schedule  
18 area if the Secretary determines that the value  
19 that would otherwise apply in such area does  
20 not accurately reflect the relative costs of such  
21 input for such area because of unique local cir-  
22 cumstances.”.

23 (2) Section 1848(i)(1)(D) of the Social Security Act  
24 (42 U.S.C. 1395w–4(i)(1)(D)) is amended by inserting

1 “(including any adjustment under subparagraph (C)  
2 thereof)” after “subsection (e)”.

3 (c) REPORT ON REVIEW PROCESS.—Not later than  
4 April 1, 1996, the Secretary of Health and Human Serv-  
5 ices (in this section referred to as the “Secretary”) shall  
6 study and report to the Committee on Finance of the Sen-  
7 ate and the Committees on Ways and Means and Energy  
8 and Commerce of the House of Representatives on—

9 (1) the data necessary to review and revise the  
10 indices established under section 1848(e)(1)(A) of  
11 the Social Security Act, including—

12 (A) the shares allocated to physicians’  
13 work effort, practice expenses (other than mal-  
14 practice expenses), and malpractice expenses;

15 (B) the weights assigned to the input com-  
16 ponents of such shares; and

17 (C) the index values assigned to such com-  
18 ponents;

19 (2) any limitations on the availability of data  
20 necessary to review and revise such indices at least  
21 every three years;

22 (3) ways of addressing such limitations, with  
23 particular attention to the development of alternative  
24 data sources for input components for which current



1 index values are based on data collected less fre-  
2 quently than every three years; and

3 (4) the costs of developing more accurate and  
4 timely data sources.

5 (d) STUDY ON LOW-VOLUME ADJUSTMENT IN ISO-  
6 LATED AREAS.—(1) Not later than July 1, 1996, the Phy-  
7 sician Payment Review Commission shall study and report  
8 to the Committee on Finance of the Senate and the Com-  
9 mittees on Ways and Means and Energy and Commerce  
10 of the House of Representatives on the feasibility and de-  
11 sirability of providing for a special adjustment to the index  
12 value of the medical equipment and supplies input compo-  
13 nent of the index used under section 1848(e) of the Social  
14 Security Act with respect to services described in para-  
15 graph (2).

16 (2) Services described in this paragraph are serv-  
17 ices—

18 (A) furnished by a physician who practices in  
19 an isolated area;

20 (B) requiring the presence of expensive medical  
21 equipment and supplies in the physician's office; and

22 (C) with respect to which the cost per service  
23 of operating the equipment is increased because of  
24 the low volume of patients of such physician.

1 **SEC. 4123. DEVELOPMENT OF MODEL STATE SCOPE OF**  
2 **PRACTICE LAW.**

3 (a) IN GENERAL.—The Secretary of Health and  
4 Human Services shall develop and publish a model law  
5 that may be adopted by States to increase the access of  
6 individuals residing in underserved rural areas to health  
7 care services by expanding the services which non-physi-  
8 cian health care professionals may provide in such areas.

9 (b) DEADLINE.—The Secretary shall publish the  
10 model law developed under subsection (a) not later than  
11 1 year after the date of the enactment of this Act.

12 **PART 3—ASSISTANCE FOR INSTITUTIONAL**  
13 **PROVIDERS**

14 **Subpart A—Community and Migrant Health**  
15 **Centers**

16 **SEC. 4131. COMMUNITY AND MIGRANT HEALTH CENTERS.**

17 (a) MIGRANT HEALTH CENTERS.—Section  
18 329(h)(1)(A) of the Public Health Service Act (42 U.S.C.  
19 254b(h)(1)(A)) is amended—

20 (1) by striking “and” after “1991,”; and

21 (2) by inserting before the period the following:

22 “, \$75,000,000 for fiscal year 1996, \$80,000,000  
23 for fiscal year 1997, \$155,000,000 for fiscal year  
24 1998, \$165,000,000 for fiscal year 1999,  
25 \$175,000,000 for fiscal year 2000, \$185,000,000 for  
26 fiscal year 2001, \$195,000,000 for fiscal year 2002,

1       \$205,000,000 for fiscal year 2003, and  
2       \$210,000,000 for fiscal year 2004”.

3       (b) COMMUNITY HEALTH CENTERS.—Section  
4       330(g)(1)(A) of the Public Health Service Act (42 U.S.C.  
5       254c(g)(1)(A)) is amended—

6               (1) by striking “and” after “1991,”; and

7               (2) by inserting before the period the following:

8       “, \$638,000,000 for fiscal year 1996, \$655,000,000  
9       for fiscal year 1997, \$845,000,000 for fiscal year  
10       1998, \$865,000,000 for fiscal year 1999,  
11       \$885,000,000 for fiscal year 2000, \$905,000,000 for  
12       fiscal year 2001, \$925,000,000 for fiscal year 2002,  
13       \$945,000,000 for fiscal year 2003, and  
14       \$965,000,000 for fiscal year 2004”.

15       **Subpart B—Emergency Medical Systems**

16       **SEC. 4141. EMERGENCY MEDICAL SERVICES.**

17       (a) ESTABLISHMENT OF FEDERAL OFFICE.—Title  
18       XII of the Public Health Service Act (42 U.S.C. 300d et  
19       seq.) is amended—

20               (1) in the heading for the title, by striking  
21       “**TRAUMA CARE**” and inserting “**EMER-**  
22       **GENCY MEDICAL AND TRAUMA CARE**  
23       **SERVICES**”;

1           (2) in the heading for part A, by striking “Gen-  
2       eral” and all that follows and inserting “General Au-  
3       thorities and Duties”; and

4           (3) by amending section 1201 to read as fol-  
5       lows:

6       **“SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY**  
7                       **MEDICAL AND TRAUMA CARE SERVICES.**

8       “(a) IN GENERAL.—The Secretary shall establish an  
9       office to be known as the Office of Emergency Medical  
10      and Trauma Care Services, which shall be headed by a  
11      director appointed by the Secretary. The Secretary shall  
12      carry out this title acting through the Director of such  
13      Office.

14      “(b) GENERAL AUTHORITIES AND DUTIES.—With  
15      respect to emergency medical services (including trauma  
16      care), the Secretary shall—

17           “(1) conduct and support research, training,  
18      evaluations, and demonstration projects;

19           “(2) foster the development of appropriate,  
20      modern systems of such services through the sharing  
21      of information among agencies and individuals in-  
22      volved in the study and provision of such services;

23           “(3) foster the development of regional systems  
24      for the provision of such services;

25           “(4) sponsor workshops and conferences;

1           “(5) as appropriate, disseminate to public and  
2           private entities information obtained in carrying out  
3           paragraphs (1) through (4);

4           “(6) provide technical assistance to State and  
5           local agencies;

6           “(7) coordinate activities of the Department of  
7           Health and Human Services; and

8           “(8) as appropriate, coordinate activities of  
9           such Department with activities of other Federal  
10          agencies.

11          “(c) CERTAIN REQUIREMENTS.—With respect to  
12          emergency medical services (including trauma care), the  
13          Secretary shall ensure that activities under subsection (b)  
14          are carried out regarding—

15               “(1) maintaining an adequate number of health  
16               professionals with expertise in the provision of the  
17               services, including hospital-based professionals and  
18               prehospital-based professionals;

19               “(2) developing, periodically reviewing, and re-  
20               vising as appropriate, in collaboration with appro-  
21               priate public and private entities, guidelines for the  
22               provision of such services (including, for various typ-  
23               ical circumstances, guidelines on the number and va-  
24               riety of professionals, on equipment, and on train-  
25               ing);

1           “(3) the appropriate use of available tech-  
2           nologies, including communications technologies; and

3           “(4) the unique needs of underserved inner-city  
4           areas and underserved rural areas.

5           “(d) GRANTS, COOPERATIVE AGREEMENTS, AND  
6           CONTRACTS.—In carrying out subsections (b) and (c), the  
7           Secretary may make grants and enter into cooperative  
8           agreements and contracts.

9           “(e) DEFINITIONS.—For purposes of this part:

10           “(1) The term ‘hospital-based professional’  
11           means a health professional (including an allied  
12           health professional) who has expertise in providing  
13           one or more emergency medical services and who  
14           normally provides the services at a medical facility.

15           “(2) The term ‘prehospital-based professional’  
16           means a health professional (including an allied  
17           health professional) who has expertise in providing  
18           one or more emergency medical services and who  
19           normally provides the services at the site of the med-  
20           ical emergency or during transport to a medical fa-  
21           cility.”.

22           (b) STATE OFFICES OF EMERGENCY MEDICAL SERV-  
23           ICES; DEMONSTRATION PROGRAM REGARDING TELE-  
24           COMMUNICATIONS.—Part A of title XII of the Public  
25           Health Service Act (42 U.S.C. 300d et seq.), as amended

1 by section 601(b) of Public Law 103-183 (107 Stat.  
2 2238), is amended—

3 (1) by redesignating sections 1202 and 1203 as  
4 sections 1203 and 1204, respectively;

5 (2) by inserting after section 1201 the following  
6 section:

7 **“SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL**  
8 **SERVICES.**

9 “(a) PROGRAM OF GRANTS.—The Secretary may  
10 make grants to States for the purpose of improving the  
11 availability and quality of emergency medical services  
12 through the operation of State offices of emergency medi-  
13 cal services.

14 “(b) REQUIREMENT OF MATCHING FUNDS.—

15 “(1) IN GENERAL.—The Secretary may not  
16 make a grant under subsection (a) unless the State  
17 involved agrees, with respect to the costs to be in-  
18 curred by the State in carrying out the purpose de-  
19 scribed in such subsection, to provide non-Federal  
20 contributions toward such costs in an amount that—

21 “(A) for the first fiscal year of payments  
22 under the grant, is not less than \$1 for each \$3  
23 of Federal funds provided in the grant;

1           “(B) for any second fiscal year of such  
2           payments, is not less than \$1 for each \$1 of  
3           Federal funds provided in the grant; and

4           “(C) for any third fiscal year of such pay-  
5           ments, is not less than \$3 for each \$1 of Fed-  
6           eral funds provided in the grant.

7           “(2) DETERMINATION OF AMOUNT OF NON-  
8           FEDERAL CONTRIBUTION.—

9           “(A) Subject to subparagraph (B), non-  
10          Federal contributions required in paragraph (1)  
11          may be in cash or in kind, fairly evaluated, in-  
12          cluding plant, equipment, or services. Amounts  
13          provided by the Federal Government, or serv-  
14          ices assisted or subsidized to any significant ex-  
15          tent by the Federal Government, may not be in-  
16          cluded in determining the amount of such non-  
17          Federal contributions.

18          “(B) The Secretary may not make a grant  
19          under subsection (a) unless the State involved  
20          agrees that—

21               “(i) for the first fiscal year of pay-  
22               ments under the grant, 100 percent or less  
23               of the non-Federal contributions required  
24               in paragraph (1) will be provided in the  
25               form of in-kind contributions;



1                   “(ii) for any second fiscal year of such  
2                   payments, not more than 50 percent of  
3                   such non-Federal contributions will be pro-  
4                   vided in the form of in-kind contributions;  
5                   and

6                   “(iii) for any third fiscal year of such  
7                   payments, such non-Federal contributions  
8                   will be provided solely in the form of cash.

9           “(c) CERTAIN REQUIRED ACTIVITIES.—The Sec-  
10   retary may not make a grant under subsection (a) unless  
11   the State involved agrees that activities carried out by an  
12   office operated pursuant to such subsection will include—

13                   “(1) coordinating the activities carried out in  
14                   the State that relate to emergency medical services;

15                   “(2) activities regarding the matters described  
16                   in paragraphs (1) through (4) section 1201(b); and

17                   “(3) identifying Federal and State programs re-  
18                   garding emergency medical services and providing  
19                   technical assistance to public and nonprofit private  
20                   entities regarding participation in such programs.

21           “(d) REQUIREMENT REGARDING ANNUAL BUDGET  
22   FOR OFFICE.—The Secretary may not make a grant  
23   under subsection (a) unless the State involved agrees that,  
24   for any fiscal year for which the State receives such a  
25   grant, the office operated pursuant to subsection (a) will

1 be provided with an annual budget of not less than  
2 \$50,000.

3 “(e) CERTAIN USES OF FUNDS.—

4 “(1) RESTRICTIONS.—The Secretary may not  
5 make a grant under subsection (a) unless the State  
6 involved agrees that—

7 “(A) if research with respect to emergency  
8 medical services is conducted pursuant to the  
9 grant, not more than 10 percent of the grant  
10 will be expended for such research; and

11 “(B) the grant will not be expended to pro-  
12 vide emergency medical services (including pro-  
13 viding cash payments regarding such services).

14 “(2) ESTABLISHMENT OF OFFICE.—Activities  
15 for which a State may expend a grant under sub-  
16 section (a) include paying the costs of establishing  
17 an office of emergency medical services for purposes  
18 of such subsection.

19 “(f) REPORTS.—The Secretary may not make a  
20 grant under subsection (a) unless the State involved  
21 agrees to submit to the Secretary reports containing such  
22 information as the Secretary may require regarding activi-  
23 ties carried out under this section by the State.

24 “(g) REQUIREMENT OF APPLICATION.—The Sec-  
25 retary may not make a grant under subsection (a) unless

1 an application for the grant is submitted to the Secretary  
2 and the application is in such form, is made in such man-  
3 ner, and contains such agreements, assurances, and infor-  
4 mation as the Secretary determines to be necessary to  
5 carry out this section.”; and

6 (3) in section 1204 (as redesignated by para-  
7 graph (1) of this subsection)—

8 (A) by redesignating subsection (c) as sub-  
9 section (d); and

10 (B) by inserting after subsection (b) the  
11 following new subsection:

12 “(c) DEMONSTRATION PROGRAM REGARDING TELE-  
13 COMMUNICATIONS.—

14 “(1) LINKAGES FOR RURAL FACILITIES.—  
15 Projects under subsection (a)(1) shall include dem-  
16 onstration projects to establish telecommunications  
17 between rural medical facilities and medical facilities  
18 that have expertise or equipment that can be utilized  
19 by the rural facilities through the telecommuni-  
20 cations.

21 “(2) MODES OF COMMUNICATION.—The Sec-  
22 retary shall ensure that the telecommunications  
23 technologies demonstrated under paragraph (1) in-  
24 clude interactive video telecommunications, static  
25 video imaging transmitted through the telephone

1 system, and facsimiles transmitted through such sys-  
2 tem.”.

3 (c) FUNDING.—Section 1232 of the Public Health  
4 Service Act (42 U.S.C. 300d-32) is amended by striking  
5 subsections (a) and (b) and inserting the following:

6 “(a) EMERGENCY MEDICAL SERVICES GEN-  
7 ERALLY.—For the purpose of carrying out section 1201  
8 other than with respect to trauma care, and for the pur-  
9 pose of carrying out section 1204(c), there are authorized  
10 to be appropriated \$2,000,000 for each of the fiscal years  
11 1996, 1997, and 1998.

12 “(b) STATE OFFICES.—For the purpose of carrying  
13 out section 1202, there are authorized to be appropriated  
14 \$3,000,000 for each of the fiscal years 1996, 1997, and  
15 1998.”.

16 **SEC. 4142. GRANTS TO STATES REGARDING AIRCRAFT FOR**  
17 **TRANSPORTING RURAL VICTIMS OF MEDICAL**  
18 **EMERGENCIES.**

19 Part E of title XII of the Public Health Service Act  
20 (42 U.S.C. 300d-51 et seq.) is amended by adding at the  
21 end the following new section:

22 **“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**  
23 **VICTIMS OF MEDICAL EMERGENCIES.**

24 “(a) IN GENERAL.—The Secretary shall make grants  
25 to States to assist such States in the creation or enhance-

1 ment of air medical transport systems that provide victims  
2 of medical emergencies in rural areas with access to treat-  
3 ments for the injuries or other conditions resulting from  
4 such emergencies.

5 “(b) APPLICATION AND PLAN.—

6 “(1) APPLICATION.—To be eligible to receive a  
7 grant under subsection (a), a State shall prepare  
8 and submit to the Secretary an application in such  
9 form, made in such manner, and containing such  
10 agreements, assurances, and information, including  
11 a State plan as required in paragraph (2), as the  
12 Secretary determines to be necessary to carry out  
13 this section.

14 “(2) STATE PLAN.—An application submitted  
15 under paragraph (1) shall contain a State plan that  
16 shall—

17 “(A) describe the intended uses of the  
18 grant proceeds and the geographic areas to be  
19 served;

20 “(B) demonstrate that the geographic  
21 areas to be served, as described under subpara-  
22 graph (A), are rural in nature;

23 “(C) demonstrate that there is a lack of  
24 facilities available and equipped to deliver ad-

1           vanded levels of medical care in the geographic  
2           areas to be served;

3           “(D) demonstrate that in utilizing the  
4           grant proceeds for the establishment or en-  
5           hancement of air medical services the State  
6           would be making a cost-effective improvement  
7           to existing ground-based or air emergency medi-  
8           cal service systems;

9           “(E) demonstrate that the State will not  
10          utilize the grant proceeds to duplicate the capa-  
11          bilities of existing air medical systems that are  
12          effectively meeting the emergency medical needs  
13          of the populations they serve;

14          “(F) demonstrate that in utilizing the  
15          grant proceeds the State is likely to achieve a  
16          reduction in the morbidity and mortality rates  
17          of the areas to be served, as determined by the  
18          Secretary;

19          “(G) demonstrate that the State, in utiliz-  
20          ing the grant proceeds, will—

21                  “(i) maintain the expenditures of the  
22                  State for air and ground medical transport  
23                  systems at a level equal to not less than  
24                  the level of such expenditures maintained  
25                  by the State for the fiscal year preceding

1           the fiscal year for which the grant is re-  
2           ceived; and

3           “(ii) ensure that recipients of direct  
4           financial assistance from the State under  
5           such grant will maintain expenditures of  
6           such recipients for such systems at a level  
7           at least equal to the level of such expendi-  
8           tures maintained by such recipients for the  
9           fiscal year preceding the fiscal year for  
10          which the financial assistance is received;

11          “(H) demonstrate that persons experienced  
12          in the field of air medical service delivery were  
13          consulted in the preparation of the State plan;  
14          and

15          “(I) contain such other information as the  
16          Secretary may determine appropriate.

17          “(c) CONSIDERATIONS IN AWARDING GRANTS.—In  
18          determining whether to award a grant to a State under  
19          this section, the Secretary shall—

20                 “(1) consider the rural nature of the areas to  
21                 be served with the grant proceeds and the services  
22                 to be provided with such proceeds, as identified in  
23                 the State plan submitted under subsection (b); and

24                 “(2) give preference to States with State plans  
25                 that demonstrate an effective integration of the pro-

1 posed air medical transport systems into a com-  
2 prehensive network or plan for regional or statewide  
3 emergency medical service delivery.

4 “(d) STATE ADMINISTRATION AND USE OF  
5 GRANT.—

6 “(1) IN GENERAL.—The Secretary may not  
7 make a grant to a State under subsection (a) unless  
8 the State agrees that such grant will be adminis-  
9 tered by the State agency with principal responsibil-  
10 ity for carrying out programs regarding the provi-  
11 sion of medical services to victims of medical emer-  
12 gencies or trauma.

13 “(2) PERMITTED USES.—A State may use  
14 amounts received under a grant awarded under this  
15 section to award subgrants to public and private en-  
16 tities operating within the State.

17 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—  
18 The Secretary may not make a grant to a State  
19 under subsection (a) unless that State agrees that,  
20 in developing and carrying out the State plan under  
21 subsection (b)(2), the State will provide public notice  
22 with respect to the plan (including any revisions  
23 thereto) and facilitate comments from interested  
24 persons.



1       “(e) NUMBER OF GRANTS.—The Secretary shall  
2 award grants under this section to not less than 7 States.

3       “(f) REPORTS.—

4               “(1) REQUIREMENT.—A State that receives a  
5 grant under this section shall annually (during each  
6 year in which the grant proceeds are used) prepare  
7 and submit to the Secretary a report that shall con-  
8 tain—

9                       “(A) a description of the manner in which  
10 the grant proceeds were utilized;

11                      “(B) a description of the effectiveness of  
12 the air medical transport programs assisted  
13 with grant proceeds; and

14                      “(C) such other information as the Sec-  
15 retary may require.

16       “(2) TERMINATION OF FUNDING.—In reviewing  
17 reports submitted under paragraph (1), if the Sec-  
18 retary determines that a State is not using amounts  
19 provided under a grant awarded under this section  
20 in accordance with the State plan submitted by the  
21 State under subsection (b), the Secretary may termi-  
22 nate the payment of amounts under such grant to  
23 the State until such time as the Secretary deter-  
24 mines that the State comes into compliance with  
25 such plan.

1       “(g) DEFINITION.—As used in this section, the term  
2 ‘rural areas’ means geographic areas that are located out-  
3 side of standard metropolitan statistical areas, as identi-  
4 fied by the Secretary.

5       “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
6 are authorized to be appropriated to make grants under  
7 this section, \$15,000,000 for each of the fiscal years 1996  
8 and 1997, \$20,000,000 for fiscal year 1998, \$25,000,000  
9 for fiscal year 1999, and \$30,000,000 for fiscal year  
10 2000.”.

11       **Subpart C—Assistance to Rural Providers**  
12                               **Under Medicare**

13       **SEC. 4151. AMENDMENTS TO ESSENTIAL ACCESS COMMU-**  
14                               **NITY HOSPITAL (EACH) PROGRAM UNDER**  
15                               **MEDICARE.**

16       (a) INCREASING NUMBER OF PARTICIPATING  
17 STATES.—Section 1820(a)(1) of the Social Security Act  
18 (42 U.S.C. 1395i-4(a)(1)) is amended by striking “7” and  
19 inserting “9”.

20       (b) TREATMENT OF INPATIENT HOSPITAL SERVICES  
21 PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

22               (1) IN GENERAL.—Section 1820(f)(1)(F) of  
23 such Act (42 U.S.C. 1395i-4(f)(1)(F)) is amended to  
24 read as follows:

1           “(F) subject to paragraph (4), provides not  
2           more than 6 inpatient beds (meeting such con-  
3           ditions as the Secretary may establish) for pro-  
4           viding inpatient care to patients requiring sta-  
5           bilization before discharge or transfer to a hos-  
6           pital, except that the facility may not provide  
7           any inpatient hospital services—

8           “(i) to any patient whose attending  
9           physician does not certify that the patient  
10          may reasonably be expected to be dis-  
11          charged or transferred to a hospital within  
12          72 hours of admission to the facility; or

13          “(ii) consisting of surgery or any  
14          other service requiring the use of general  
15          anesthesia (other than surgical procedures  
16          specified by the Secretary under section  
17          1833(i)(1)(A)), unless the attending physi-  
18          cian certifies that the risk associated with  
19          transferring the patient to a hospital for  
20          such services outweighs the benefits of  
21          transferring the patient to a hospital for  
22          such services.”.

23           (2) LIMITATION ON AVERAGE LENGTH OF  
24          STAY.—Section 1820(f) of such Act (42 U.S.C.

1       1395i-4(f)) is amended by adding at the end the fol-  
2       lowing new paragraph:

3           “(4) LIMITATION ON AVERAGE LENGTH OF IN-  
4       PATIENT STAYS.—The Secretary may terminate a  
5       designation of a rural primary care hospital under  
6       paragraph (1) if the Secretary finds that the average  
7       length of stay for inpatients at the facility during  
8       the previous year in which the designation was in ef-  
9       fect exceeded 72 hours. In determining the compli-  
10      ance of a facility with the requirement of the pre-  
11      vious sentence, there shall not be taken into account  
12      periods of stay of inpatients in excess of 72 hours  
13      to the extent such periods exceed 72 hours because  
14      transfer to a hospital is precluded because of inclem-  
15      ent weather or other emergency conditions.”.

16           (3) CONFORMING AMENDMENT.—Section  
17      1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is  
18      amended by striking “such services” and all that fol-  
19      lows and inserting “the individual may reasonably be  
20      expected to be discharged or transferred to a hos-  
21      pital within 72 hours after admission to the rural  
22      primary care hospital.”.

23           (4) GAO REPORTS.—Not later than 2 years  
24      after the date of the enactment of this Act, the

1       Comptroller General shall submit reports to Con-  
2       gress on—

3               (A) the application of the requirements  
4               under section 1820(f) of the Social Security Act  
5               (as amended by this subsection) that rural pri-  
6               mary care hospitals provide inpatient care only  
7               to those individuals whose attending physicians  
8               certify may reasonably be expected to be dis-  
9               charged within 72 hours after admission and  
10              maintain an average length of inpatient stay  
11              during a year that does not exceed 72 hours;  
12              and

13              (B) the extent to which such requirements  
14              have resulted in such hospitals providing inpa-  
15              tient care beyond their capabilities or have lim-  
16              ited the ability of such hospitals to provide  
17              needed services.

18       (c) DESIGNATION OF HOSPITALS.—

19              (1) PERMITTING DESIGNATION OF HOSPITALS  
20       LOCATED IN URBAN AREAS.—

21              (A) IN GENERAL.—Section 1820 of such  
22       Act (42 U.S.C. 1395i-4) is amended—

23                      (i) by striking paragraph (1) of sub-  
24                      section (e) and redesignating paragraphs

1 (2) through (6) as paragraphs (1) through  
2 (5);

3 (ii) in subsection (e)(1)(A) (as redes-  
4 ignated by subparagraph (A))—

5 (I) by striking “is located” and  
6 inserting “except in the case of a hos-  
7 pital located in an urban area, is lo-  
8 cated”,

9 (II) by striking “, (ii)” and in-  
10 sserting “or (ii)”, and

11 (III) by striking “or (iii)” and all  
12 that follows through “section,”; and

13 (iii) in subsection (i)(1)(B), by strik-  
14 ing “paragraph (3)” and inserting “para-  
15 graph (2)”.

16 (B) NO CHANGE IN MEDICARE PROSPEC-  
17 TIVE PAYMENT.—Section 1886(d)(5)(D) of  
18 such Act (42 U.S.C. 1395ww(d)(5)(D)) is  
19 amended—

20 (i) in clause (iii)(III), by inserting “lo-  
21 cated in a rural area and” after “that is”,  
22 and

23 (ii) in clause (v), by inserting “located  
24 in a rural area and” after “in the case of  
25 a hospital”.

1           (2) PERMITTING HOSPITALS LOCATED IN AD-  
2       JOINING STATES TO PARTICIPATE IN STATE PRO-  
3       GRAM.—

4           (A) IN GENERAL.—Section 1820 of such  
5       Act (42 U.S.C. 1395i-4) is amended—

6                   (i) by redesignating subsection (k) as  
7                   subsection (l); and

8                   (ii) by inserting after subsection (j)  
9       the following new subsection:

10       “(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN  
11       PARTICIPATING STATES.—Notwithstanding any other  
12       provision of this section—

13               “(1) for purposes of including a hospital or fa-  
14       cility as a member institution of a rural health net-  
15       work, a State may designate a hospital or facility  
16       that is not located in the State as an essential access  
17       community hospital or a rural primary care hospital  
18       if the hospital or facility is located in an adjoining  
19       State and is otherwise eligible for designation as  
20       such a hospital;

21               “(2) the Secretary may designate a hospital or  
22       facility that is not located in a State receiving a  
23       grant under subsection (a)(1) as an essential access  
24       community hospital or a rural primary care hospital  
25       if the hospital or facility is a member institution of

1 a rural health network of a State receiving a grant  
2 under such subsection; and

3 “(3) a hospital or facility designated pursuant  
4 to this subsection shall be eligible to receive a grant  
5 under subsection (a)(2).”.

6 (B) CONFORMING AMENDMENTS.—(i) Sec-  
7 tion 1820(c)(1) of such Act (42 U.S.C. 1395i-  
8 4(c)(1)) is amended by striking “paragraph  
9 (3)” and inserting “paragraph (3) or subsection  
10 (k)”.

11 (ii) Paragraphs (1)(A) and (2)(A) of sec-  
12 tion 1820(i) of such Act (42 U.S.C. 1395i-4(i))  
13 are each amended—

14 (I) in clause (i), by striking “(a)(1)”  
15 and inserting “(a)(1) (except as provided  
16 in subsection (k))”, and

17 (II) in clause (ii), by striking “sub-  
18 paragraph (B)” and inserting “subpara-  
19 graph (B) or subsection (k)”.

20 (d) SKILLED NURSING SERVICES IN RURAL PRIMARY  
21 CARE HOSPITALS.—Section 1820(f)(3) of such Act (42  
22 U.S.C. 1395i-4(f)(3)) is amended by striking “because the  
23 facility” and all that follows and inserting the following:  
24 “because, at the time the facility applies to the State for  
25 designation as a rural primary care hospital, there is in



1 effect an agreement between the facility and the Secretary  
2 under section 1883 under which the facility's inpatient  
3 hospital facilities are used for the furnishing of extended  
4 care services, except that the number of beds used for the  
5 furnishing of such services may not exceed the total num-  
6 ber of licensed inpatient beds at the time the facility ap-  
7 plies to the State for such designation (minus the number  
8 of inpatient beds used for providing inpatient care pursu-  
9 ant to paragraph (1)(F)). For purposes of the previous  
10 sentence, the number of beds of the facility used for the  
11 furnishing of extended care services shall not include any  
12 beds of a unit of the facility that is licensed as a distinct-  
13 part skilled nursing facility at the time the facility applies  
14 to the State for designation as a rural primary care hos-  
15 pital.”.

16 (e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE  
17 PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY  
18 CARE HOSPITAL SERVICES.—Section 1814(l)(2) of such  
19 Act (42 U.S.C. 1395f(l)(2)) is amended by striking “Jan-  
20 uary 1, 1993” and inserting “January 1, 1996”.

21 (f) PAYMENT FOR OUTPATIENT RURAL PRIMARY  
22 CARE HOSPITAL SERVICES.—

23 (1) IMPLEMENTATION OF PROSPECTIVE PAY-  
24 MENT SYSTEM.—Section 1834(g) of such Act (42  
25 U.S.C. 1395m(g)) is amended—

1 (A) in paragraph (1), by striking “during  
2 a year before 1993” and inserting “during a  
3 year before the prospective payment system de-  
4 scribed in paragraph (2) is in effect”; and

5 (B) in paragraph (2), by striking “January  
6 1, 1993,” and inserting “January 1, 1996,”.

7 (2) NO USE OF CUSTOMARY CHARGE IN DETER-  
8 MINING PAYMENT.—Section 1834(g)(1) of such Act  
9 (42 U.S.C. 1395m(g)(1)) is amended by adding at  
10 the end the following new flush sentence: “The  
11 amount of payment shall be determined under either  
12 method without regard to the amount of the cus-  
13 tomary or other charge.”.

14 (g) CLARIFICATION OF PHYSICIAN STAFFING RE-  
15 QUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—  
16 Section 1820(f)(1)(H) of such Act (42 U.S.C. 1395i-  
17 4(f)(1)(H)) is amended by striking the period and insert-  
18 ing the following: “, except that in determining whether  
19 a facility meets the requirements of this subparagraph,  
20 subparagraphs (E) and (F) of that paragraph shall be ap-  
21 plied as if any reference to a ‘physician’ is a reference  
22 to a physician as defined in section 1861(r)(1).”.

23 (h) TECHNICAL AMENDMENTS RELATING TO PART  
24 A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILL-

1 NESS.—(1) Section 1812(a)(1) of such Act (42 U.S.C.  
2 1395d(a)(1)) is amended—

3 (A) by striking “inpatient hospital services” the  
4 first place it appears and inserting “inpatient hos-  
5 pital services or inpatient rural primary care hos-  
6 pital services”;

7 (B) by striking “inpatient hospital services” the  
8 second place it appears and inserting “such serv-  
9 ices”; and

10 (C) by striking “and inpatient rural primary  
11 care hospital services”.

12 (2) Sections 1813(a) and 1813(b)(3)(A) of such Act  
13 (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended  
14 by striking “inpatient hospital services” each place it ap-  
15 pears and inserting “inpatient hospital services or inpa-  
16 tient rural primary care hospital services”.

17 (3) Section 1813(b)(3)(B) of such Act (42 U.S.C.  
18 1395e(b)(3)(B)) is amended by striking “inpatient hos-  
19 pital services” and inserting “inpatient hospital services,  
20 inpatient rural primary care hospital services”.

21 (4) Section 1861(a) of such Act (42 U.S.C. 1395x(a))  
22 is amended—

23 (A) in paragraph (1), by striking “inpatient  
24 hospital services” and inserting “inpatient hospital

1 services, inpatient rural primary care hospital serv-  
2 ices”; and

3 (B) in paragraph (2), by striking “hospital”  
4 and inserting “hospital or rural primary care hos-  
5 pital”.

6 (i) AUTHORIZATION OF APPROPRIATIONS.—Section  
7 1820(l) of such Act (42 U.S.C. 1395i–4(l)), as redesign-  
8 nated by subsection (c)(2)(A), is amended by striking  
9 “1990, 1991, and 1992” and inserting “1990 through  
10 2000”.

11 (j) EFFECTIVE DATE.—The amendments made by  
12 this section shall take effect on the date of the enactment  
13 of this Act.

14 **SEC. 4152. RURAL EMERGENCY ACCESS CARE HOSPITALS**  
15 **DESCRIBED.**

16 (a) IN GENERAL.—Section 1861 of the Social Secu-  
17 rity Act (42 U.S.C. 1395x) is amended by adding at the  
18 end the following new subsection:

19 “Rural Emergency Access Care Hospital; Rural  
20 Emergency Access Care Hospital Services

21 “(oo)(1) The term ‘rural emergency access care hos-  
22 pital’ means, for a fiscal year, a facility with respect to  
23 which the Secretary finds the following:

24 “(A) The facility is located in a rural area (as  
25 defined in section 1886(d)(2)(D)).

1           “(B) The facility was a hospital under this title  
2           at any time during the 5-year period that ends on  
3           the date of the enactment of this subsection.

4           “(C) The facility is in danger of closing due to  
5           low inpatient utilization rates and negative operating  
6           losses, and the closure of the facility would limit the  
7           access of individuals residing in the facility’s service  
8           area to emergency services.

9           “(D) The facility has entered into (or plans to  
10          enter into) an agreement with a hospital with a par-  
11          ticipation agreement in effect under section 1866(a),  
12          and under such agreement the hospital shall accept  
13          patients transferred to the hospital from the facility  
14          and receive data from and transmit data to the facil-  
15          ity.

16          “(E) There is a practitioner who is qualified to  
17          provide advanced cardiac life support services (as de-  
18          termined by the State in which the facility is lo-  
19          cated) on-site at the facility on a 24-hour basis.

20          “(F) A physician is available on-call to provide  
21          emergency medical services on a 24-hour basis.

22          “(G) The facility meets such staffing require-  
23          ments as would apply under section 1861(e) to a  
24          hospital located in a rural area, except that—

1           “(i) the facility need not meet hospital  
2 standards relating to the number of hours dur-  
3 ing a day, or days during a week, in which the  
4 facility must be open, except insofar as the fa-  
5 cility is required to provide emergency care on  
6 a 24-hour basis under subparagraphs (E) and  
7 (F); and

8           “(ii) the facility may provide any services  
9 otherwise required to be provided by a full-time,  
10 on-site dietician, pharmacist, laboratory techni-  
11 cian, medical technologist, or radiological tech-  
12 nologist on a part time, off-site basis.

13           “(H) The facility meets the requirements appli-  
14 cable to clinics and facilities under subparagraphs  
15 (C) through (J) of paragraph (2) of section  
16 1861(aa) and of clauses (ii) and (iv) of the second  
17 sentence of such paragraph (or, in the case of the  
18 requirements of subparagraph (E), (F), or (J) of  
19 such paragraph, would meet the requirements if any  
20 reference in such subparagraph to a ‘nurse practi-  
21 tioner’ or to ‘nurse practitioners’ was deemed to be  
22 a reference to a ‘nurse practitioner or nurse’ or to  
23 ‘nurse practitioners or nurses’); except that in deter-  
24 mining whether a facility meets the requirements of  
25 this subparagraph, subparagraphs (E) and (F) of

1       that paragraph shall be applied as if any reference  
2       to a ‘physician’ is a reference to a physician as de-  
3       fined in section 1861(r)(1).

4       “(2) The term ‘rural emergency access care hospital  
5       services’ means the following services provided by a rural  
6       emergency access care hospital:

7               “(A) An appropriate medical screening exam-  
8       ination (as described in section 1867(a)).

9               “(B) Necessary stabilizing examination and  
10       treatment services for an emergency medical condi-  
11       tion and labor (as described in section 1867(b)).”.

12       (b) REQUIRING RURAL EMERGENCY ACCESS CARE  
13       HOSPITALS TO MEET HOSPITAL ANTI-DUMPING RE-  
14       QUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C.  
15       1395dd(e)(5)) is amended by striking “1861(mm)(1))”  
16       and inserting “1861(mm)(1)) and a rural emergency ac-  
17       cess care hospital (as defined in section 1861(oo)(1))”.

18       **SEC. 4153. COVERAGE OF AND PAYMENT FOR SERVICES.**

19       (a) COVERAGE UNDER PART B.—Section 1832(a)(2)  
20       of the Social Security Act (42 U.S.C. 1395k(a)(2)) is  
21       amended—

22               (1) by striking “and” at the end of subpara-  
23       graph (I);

24               (2) by striking the period at the end of sub-  
25       paragraph (J) and inserting “; and”; and

1           (3) by adding at the end the following new sub-  
2 paragraph:

3           “(K) rural emergency access care hospital  
4 services (as defined in section 1861(oo)(2)).”.

5           (b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT  
6 RURAL PRIMARY CARE HOSPITAL SERVICES.—

7           (1) IN GENERAL.—Section 1833(a)(6) of the  
8 Social Security Act (42 U.S.C. 1395l(a)(6)) is  
9 amended by striking “services,” and inserting “serv-  
10 ices and rural emergency access care hospital serv-  
11 ices,”.

12           (2) PAYMENT METHODOLOGY DESCRIBED.—  
13 Section 1834(g) of such Act (42 U.S.C. 1395m(g))  
14 is amended—

15           (A) in the heading, by striking “SERV-  
16 ICES” and inserting “SERVICES AND RURAL  
17 EMERGENCY ACCESS CARE HOSPITAL SERV-  
18 ICES”;

19           (B) in paragraph (1), by striking “during  
20 a year before 1993” and inserting “during a  
21 year before the prospective payment system de-  
22 scribed in paragraph (2) is in effect”;

23           (C) in paragraph (1), by adding at the end  
24 the following: “The amount of payment shall be  
25 determined under either method without regard



1 to the amount of the customary or other  
2 charge.”;

3 (D) in paragraph (2), by striking “Janu-  
4 ary 1, 1993,” and inserting “January 1,  
5 1996,”; and

6 (E) by adding at the end the following new  
7 paragraph:

8 “(3) APPLICATION OF METHODS TO PAYMENT  
9 FOR RURAL EMERGENCY ACCESS CARE HOSPITAL  
10 SERVICES.—The amount of payment for rural emer-  
11 gency access care hospital services provided during  
12 a year shall be determined using the applicable  
13 method provided under this subsection for determin-  
14 ing payment for outpatient rural primary care hos-  
15 pital services during the year.”.

16 **SEC. 4154. EFFECTIVE DATE.**

17 The amendments made by this subpart shall apply  
18 to fiscal years beginning on or after October 1, 1994.

19 **Subpart D—Demonstration Projects to En-**  
20 **courage Primary Care and Rural-Based**  
21 **Graduate Medical Education**

22 **SEC. 4161. STATE AND CONSORTIUM DEMONSTRATION**  
23 **PROJECTS.**

24 (a) IN GENERAL.—

1           (1) PARTICIPATION OF STATES AND CONSOR-  
2           TIA.—The Secretary shall establish and conduct a  
3           demonstration project to increase the number and  
4           percentage of medical students entering primary  
5           care practice relative to those entering nonprimary  
6           care practice under which the Secretary shall make  
7           payments in accordance with subsection (d)—

8                   (A) to not more than 10 States for the  
9                   purpose of testing and evaluating mechanisms  
10                  to meet the goals described in section 4162;  
11                  and

12                  (B) to not more than 10 health care train-  
13                  ing consortia for the purpose of testing and  
14                  evaluating mechanisms to meet such goals.

15           (2) EXCLUSION OF CONSORTIA IN PARTICIPAT-  
16           ING STATES.—A consortia may not receive payments  
17           under the demonstration project under paragraph  
18           (1)(B) if any of its members is located in a State  
19           receiving payments under the project under para-  
20           graph (1)(A).

21           (b) APPLICATIONS.—

22                   (1) IN GENERAL.—Each State and consortium  
23                   desiring to conduct a demonstration project under  
24                   this section shall prepare and submit to the Sec-  
25                   retary an application, at such time, in such manner,

1       and containing such information as the Secretary  
2       may require to assure that the State or consortium  
3       will meet the goals described in section 4162. In the  
4       case of an application of a State, the application  
5       shall include—

6               (A) information demonstrating that the  
7       State has consulted with interested parties with  
8       respect to the project, including State medical  
9       associations, State hospital associations, and  
10      medical schools located in the State;

11              (B) an assurance that no hospital conduct-  
12      ing an approved medical residency training pro-  
13      gram in the State will lose more than 10 per-  
14      cent of such hospital's approved medical resi-  
15      dency positions in any year as a result of the  
16      project; and

17              (C) an explanation of a plan for evaluating  
18      the impact of the project in the State.

19              (2) APPROVAL OF APPLICATIONS.—A State or  
20      consortium that submits an application under para-  
21      graph (1) may begin a demonstration project under  
22      this subsection—

23              (A) upon approval of such application by  
24      the Secretary; or

1           (B) at the end of the 60-day period begin-  
2           ning on the date such application is submitted,  
3           unless the Secretary denies the application dur-  
4           ing such period.

5           (3) NOTICE AND COMMENT.—A State or con-  
6           sortium shall issue a public notice on the date it  
7           submits an application under paragraph (1) which  
8           contains a general description of the proposed dem-  
9           onstration project. Any interested party may com-  
10          ment on the proposed demonstration project to the  
11          State or consortium or the Secretary during the 30-  
12          day period beginning on the date the public notice  
13          is issued.

14          (c) SPECIFIC REQUIREMENTS FOR PARTICIPANTS.—

15               (1) REQUIREMENTS FOR STATES.—Each State  
16               participating in the demonstration project under this  
17               subtitle shall use the payments provided under sub-  
18               section (d) to test and evaluate either of the follow-  
19               ing mechanisms to increase the number and percent-  
20               age of medical students entering primary care prac-  
21               tice relative to those entering nonprimary care prac-  
22               tice:

23                       (A) USE OF ALTERNATIVE WEIGHTING  
24                       FACTORS.—

1           (i) IN GENERAL.—The State may  
2           make payments to hospitals in the State  
3           for direct graduate medical education costs  
4           in amounts determined under the meth-  
5           odology provided under section 1886(h) of  
6           the Social Security Act, except that the  
7           State shall apply weighting factors that are  
8           different than the weighting factors other-  
9           wise set forth in section 1886(h)(4)(C) of  
10          the Social Security Act.

11          (ii) USE OF PAYMENTS FOR PRIMARY  
12          CARE RESIDENTS.—In applying different  
13          weighting factors under clause (i), the  
14          State shall ensure that the amount of pay-  
15          ment made to hospitals for costs attrib-  
16          utable to primary care residents shall be  
17          greater than the amount that would have  
18          been paid to hospitals for costs attributable  
19          to such residents if the State had applied  
20          the weighting factors otherwise set forth in  
21          section 1886(h)(4)(C) of the Social Secu-  
22          rity Act.

23          (B) PAYMENTS FOR MEDICAL EDUCATION  
24          THROUGH CONSORTIUM.—The State may make  
25          payments for graduate medical education costs

1 through payments to a health care training con-  
2 sortium (or through any entity identified by  
3 such a consortium as appropriate for receiving  
4 payments on behalf of the consortium) that is  
5 established in the State but that is not other-  
6 wise participating in the demonstration project.

7 (2) REQUIREMENTS FOR CONSORTIUM.—

8 (A) IN GENERAL.—In the case of a consor-  
9 tium participating in the demonstration project  
10 under this subtitle, the Secretary shall make  
11 payments for graduate medical education costs  
12 through a health care training consortium  
13 whose members provide medical residency train-  
14 ing (or through any entity identified by such a  
15 consortium as appropriate for receiving pay-  
16 ments on behalf of the consortium).

17 (B) USE OF PAYMENTS.—

18 (i) IN GENERAL.—Each consortium  
19 receiving payments under subparagraph  
20 (A) shall use such funds to conduct activi-  
21 ties which test and evaluate mechanisms to  
22 increase the number and percentage of  
23 medical students entering primary care  
24 practice relative to those entering  
25 nonprimary care practice, and may use

1           such funds for the operation of the consor-  
2           tium.

3                   (ii) PAYMENTS TO PARTICIPATING  
4           PROGRAMS.—The consortium shall ensure  
5           that the majority of the payments received  
6           under subparagraph (A) are directed to  
7           consortium members for primary care resi-  
8           dency programs, and shall designate for  
9           each resident assigned to the consortium a  
10          hospital operating an approved medical  
11          residency training program for purposes of  
12          enabling the Secretary to calculate the con-  
13          sortium's payment amount under the  
14          project. Such hospital shall be the hospital  
15          where the resident receives the majority of  
16          the resident's hospital-based, non-  
17          ambulatory training experience.

18          (d) ALLOCATION OF PORTION OF MEDICARE GME  
19          PAYMENTS FOR ACTIVITIES UNDER PROJECT.—Notwith-  
20          standing any provision of title XVIII of the Social Security  
21          Act, the following rules apply with respect to each State  
22          and each health care training consortium participating in  
23          the demonstration project established under this section  
24          during a year:

25                  (1) In the case of a State—

1           (A) the Secretary shall reduce the amount  
2 of each payment made to hospitals in the State  
3 during the year for direct graduate medical  
4 education costs under section 1886(h) of the  
5 Social Security Act by 3 percent; and

6           (B) the Secretary shall pay the State an  
7 amount equal to the Secretary's estimate of the  
8 sum of the reductions made during the year  
9 under subparagraph (A) (as adjusted by the  
10 Secretary in subsequent years for over- or  
11 under-estimations in the amount estimated  
12 under this subparagraph in previous years).

13       (2) In the case of a consortium—

14           (A) the Secretary shall reduce the amount  
15 of each payment made to hospitals who are  
16 members of the consortium during the year for  
17 direct graduate medical education costs under  
18 section 1886(h) of the Social Security Act by 3  
19 percent; and

20           (B) the Secretary shall pay the consortium  
21 an amount equal to the Secretary's estimate of  
22 the sum of the reductions made during the year  
23 under subparagraph (A) (as adjusted by the  
24 Secretary in subsequent years for over- or



1           under-estimations in the amount estimated  
2           under this subparagraph in previous years).

3           (e) ADDITIONAL GRANT FOR PLANNING AND EVAL-  
4 UATION.—

5           (1) IN GENERAL.—The Secretary may award  
6           grants to States and consortia participating in the  
7           demonstration project under this section for the pur-  
8           pose of developing and evaluating such projects. A  
9           State or consortia may conduct such an evaluation  
10          or contract with a private entity to conduct the eval-  
11          uation. Each State and consortia desiring to receive  
12          a grant under this paragraph shall prepare and sub-  
13          mit to the Secretary an application, at such time, in  
14          such manner, and containing such information as  
15          the Secretary may require.

16          (2) AUTHORIZATION OF APPROPRIATIONS.—  
17          There are authorized to be appropriated such sums  
18          as may be necessary for grants under this paragraph  
19          for fiscal years 1996 through 2000.

20          (f) DURATION.—A demonstration project under this  
21          section shall be conducted for a period not to exceed 5  
22          years. The Secretary may terminate a project if the Sec-  
23          retary determines that the State or consortium conducting  
24          the project is not in substantial compliance with the terms  
25          of the application approved by the Secretary.

1 (g) EVALUATIONS AND REPORTS.—

2 (1) EVALUATIONS.—Each State or consortium  
3 participating in the demonstration project shall sub-  
4 mit to the Secretary a final evaluation within 360  
5 days of the termination of the State or consortium's  
6 participation and such interim evaluations as the  
7 Secretary may require.

8 (2) REPORTS TO CONGRESS.—Not later than  
9 360 days after the first demonstration project under  
10 this subtitle begins, and annually thereafter for each  
11 year in which such a project is conducted, the Sec-  
12 retary shall submit a report to Congress which eval-  
13 uates the effectiveness of the State and consortium  
14 activities conducted under such projects and includes  
15 any legislative recommendations determined appro-  
16 priate by the Secretary.

17 (h) MAINTENANCE OF EFFORT.—Any funds available  
18 for the activities covered by a demonstration project under  
19 this subtitle shall supplement, and shall not supplant,  
20 funds that are expended for similar purposes under any  
21 State, regional, or local program.

22 **SEC. 4162. GOALS FOR PROJECTS.**

23 The goals referred to in this section for a State or  
24 consortium participating in the demonstration project  
25 under this subtitle are as follows:

1           (1) The training of an equal number of physi-  
2           cian and non-physician primary care providers.

3           (2) The recruiting of residents for graduate  
4           medical education training programs who received a  
5           portion of undergraduate training in a rural area.

6           (3) The allocation of not less than 50 percent  
7           of the training spent in a graduate medical residency  
8           training program at sites at which acute care inpa-  
9           tient hospital services are not furnished.

10          (4) The rotation of residents in approved medi-  
11          cal residency training programs among practices  
12          that serve residents of rural areas.

13          (5) The development of a plan under which,  
14          after a 5-year transition period, not less than 50  
15          percent of the residents who begin an initial resi-  
16          dency period in an approved medical residency train-  
17          ing program shall be primary care residents.

18   **SEC. 4163. DEFINITIONS.**

19       In this subpart:

20           (1) **APPROVED MEDICAL RESIDENCY TRAINING**  
21       **PROGRAM.**—The term “approved medical residency  
22       training program” has the meaning given such term  
23       in section 1886(h)(5)(A) of the Social Security Act.

24           (2) **HEALTH CARE TRAINING CONSORTIUM.**—  
25       The term “health care training consortium” means

1 a State, regional, or local entity consisting of at  
2 least one of each of the following:

3 (A) A hospital operating an approved med-  
4 ical residency training program at which resi-  
5 dents receive training at ambulatory training  
6 sites located in rural areas.

7 (B) A school of medicine or osteopathic  
8 medicine.

9 (C) A school of allied health or a program  
10 for the training of physician assistants (as such  
11 terms are defined in section 799 of the Public  
12 Health Service Act).

13 (D) A school of nursing (as defined in sec-  
14 tion 853 of the Public Health Service Act).

15 (3) PRIMARY CARE.—The term “primary care”  
16 means family practice, general internal medicine,  
17 general pediatrics, and obstetrics and gynecology.

18 (4) RESIDENT.—The term “resident” has the  
19 meaning given such term in section 1886(h)(5)(H)  
20 of the Social Security Act.

21 (5) RURAL AREA.—The term “rural area” has  
22 the meaning given such term in section  
23 1886(d)(2)(D) of the Social Security Act.

1 **PART 4—HOSPITAL AFFILIATED PRIMARY CARE**  
2 **CENTER**

3 **SEC. 4171. HOSPITAL-AFFILIATED PRIMARY CARE CEN-**  
4 **TERS.**

5 (a) DEFINITIONS.—For purposes of this section:

6 (1) COMMUNITY HOSPITAL.—The term “com-  
7 munity hospital” means a public general hospital,  
8 owned and operated by a State, county or local unit  
9 of government, or a private community hospital  
10 that—

11 (A) has less than 50 beds; and

12 (B) primarily serves a medically under-  
13 served population as defined in section  
14 330(b)(3) of the Public Health Service Act (42  
15 U.S.C. 254c(b)(3)) or a health professional  
16 shortage area as defined in section 322(a)(1) of  
17 such Act (42 U.S.C. 254c(a)(1)).

18 (2) HOSPITAL-AFFILIATED PRIMARY CARE CEN-  
19 TER.—The term “hospital-affiliated primary care  
20 center” (referred to in this section as a “primary  
21 care center”) means a distinct administrative unit of  
22 a community hospital, located in, or adjacent to, the  
23 hospital, that—

24 (A) delivers primary health services as de-  
25 fined in section 330(b)(1) of such Act (42  
26 U.S.C. 354c(b)(1)) to a catchment area deter-

1           mined by the hospital and approved by the Sec-  
2           retary; and

3           (B) provides referrals to providers of sup-  
4           plemental health services as defined in section  
5           330(b)(2) of such Act (42 U.S.C. 354c(b)(2)).

6           (3) PRIMARY CARE GROUP PRACTICE.—

7           (A) The term “primary care group prac-  
8           tice” means any combination of 3 or more pri-  
9           mary care physicians who are—

10           (i) organized to provide primary  
11           health services in a manner that is consist-  
12           ent with the needs of the population  
13           served;

14           (ii) located in, or adjacent to, the  
15           community hospital;

16           (iii) who have admitting privileges at  
17           the community hospital; and

18           (iv)(I) who are salaried by the hos-  
19           pital such that a majority of the members  
20           of the group practice is full time in the pri-  
21           mary care center; or

22           (II) who are organized into a legal en-  
23           tity (partnership, corporation, or profes-  
24           sional association) that has a contract ap-  
25           proved by the Secretary with the commu-

1           nity hospital to provide primary health  
2           services.

3           (B) SPECIAL RULE FOR HPSAS AND NEAR-  
4           HPSAS.—In the case of a group that is located  
5           in an area that—

6                   (i) is designated as a primary care  
7                   health professional shortage area under  
8                   section 332 of the Public Health Service  
9                   Act (42 U.S.C. 254e); or

10                   (ii) would meet the requirements for  
11                   designation as a primary care health pro-  
12                   fessional shortage area if there were 25  
13                   percent fewer physicians in the area;

14           the requirement that a group practice have 3 or  
15           more primary care physicians may be met by  
16           substituting a nurse practitioner or a physician  
17           assistant for 1 member of the group.

18           (C) SPECIAL RULE FOR FRONTIER  
19           AREAS.—In the case of a group that is located  
20           in a frontier area, subparagraph (A) shall be  
21           applied by substituting “two” for “three” in the  
22           matter preceding clause (i).

23           (D) OTHER REQUIREMENTS FOR GROUP.—

24                   (i) physicians in specialties other than  
25                   primary care specialties may become mem-

1           bers of a primary care group practice as  
2           needed, but may not be used to satisfy the  
3           requirement of subsection (b)(2)(D); and

4           (ii) nonphysician providers, particu-  
5           larly physician assistants, certified nurse  
6           midwives, and nurse practitioners, shall be  
7           used where practicable in concert with the  
8           physicians of a primary care group prac-  
9           tice.

10          (4) FRONTIER AREA.—The term “frontier  
11          area” means a county in which there are 6 or fewer  
12          individuals residing per square mile.

13          (5) PRIMARY CARE PHYSICIAN.—The term “pri-  
14          mary care physician” means a physician in the spe-  
15          cialty of family practice, general internal medicine,  
16          general pediatrics, or obstetrics and gynecology.

17          (6) PRIMARY CARE RESIDENT.—The term “pri-  
18          mary care resident” means a graduate physician in  
19          training, whose training program is approved by ap-  
20          propriate certifying bodies and is in a primary care  
21          specialty.

22          (b) ESTABLISHMENT OF GRANT PROGRAM.—

23          (1) IN GENERAL.—The Secretary of Health and  
24          Human Services (referred to in this section as the  
25          “Secretary”) shall make grants to community hos-



1       pitals to assist such hospitals in planning, develop-  
2       ing, and operating primary care services in medically  
3       underserved areas. In making such grants, the Sec-  
4       retary shall avoid duplication of efforts in areas  
5       where existing community health centers, migrant  
6       health centers, rural emergency access care hos-  
7       pitals, federally qualified health centers, and other  
8       facilities are adequate to meet the needs of the medi-  
9       cally underserved population.

10       (2) ELIGIBILITY FOR GRANTS.—In order to be  
11       eligible for a grant under this subsection, a commu-  
12       nity hospital shall submit an application that con-  
13       tains or is supported by assurances, satisfactory to  
14       the Secretary, that—

15               (A) the services of the primary care center  
16               will be delivered through a primary care group  
17               practice;

18               (B) to the extent practicable, primary  
19               health services in the community hospital will  
20               be delivered only through the primary care cen-  
21               ter;

22               (C) qualified personnel trained in triage  
23               will be placed in the emergency room, the out-  
24               patient department, and the primary care cen-

1           ter to screen and direct patients to the appro-  
2           priate location for care;

3           (D) each patient of the primary care cen-  
4           ter will have an identified member of the group  
5           practice responsible for continuous management  
6           of the patient, including emergency services and  
7           referrals of the patients for inpatient or out-  
8           patient services;

9           (E) to the extent practicable, excess facili-  
10          ties and equipment in or owned by the commu-  
11          nity hospital will be covered for use in the pri-  
12          mary care center;

13          (F) the hospital and the primary care cen-  
14          ter will avoid unnecessary duplication of facili-  
15          ties and equipment, except that the primary  
16          care center may install appropriate support  
17          equipment for routine primary health services;

18          (G) the primary care center will be main-  
19          tained as a separate and distinct cost and reve-  
20          nue center for accounting purposes;

21          (H) the primary care center will be oper-  
22          ated in accordance with all of the requirements  
23          specified for community health centers in sec-  
24          tion 330(e)(3) of the Public Health Service Act  
25          (other than subparagraph (G));

1 (I) the hospital has an advisory committee  
2 that—

3 (i) is composed of individuals, a ma-  
4 jority of whom are health consumers in the  
5 catchment area of the hospital; and

6 (ii) meets at least 6 times a year to  
7 review the operations of the primary care  
8 center and develop recommendations to the  
9 governing board of the hospital about the  
10 operation of the center and the types of  
11 services to be provided; and

12 (J) the primary care center will maintain  
13 an information program for its patients that  
14 fully discloses—

15 (i) the covered professional services  
16 and referral capabilities offered by the pri-  
17 mary care center; and

18 (ii) the method by which patients of  
19 the primary care center may resolve griev-  
20 ances about billing for covered professional  
21 services and the quality of such services.

22 (3) OTHER REQUIREMENTS.—

23 (A) USE OF PRIMARY CARE RESIDENTS.—

24 (i) Primary health services may be delivered by  
25 primary care residents if such services are deliv-

1           ered under the supervision of a member of the  
2           group practice.

3           (ii)(I) Medical and other health science  
4           students may receive primary care training in  
5           the primary care center, except that no full-  
6           time member of the group practice may also  
7           spend full time in the teaching of residents and  
8           students.

9           (II) The Secretary shall issue regulations  
10          to assure that teaching does not detract signifi-  
11          cantly from the actual delivery of service in the  
12          primary care center.

13          (B) COSTS OF PRIMARY CARE CENTERS.—

14          (i) Only costs clearly associated with the provi-  
15          sion of services in the primary care setting may  
16          be assigned to a primary care center.

17          (ii) Inpatient-related costs may not be in-  
18          cluded in the costs of operating a primary care  
19          center.

20          (iii) Costs associated with the education  
21          and training of residents, medical, and other  
22          health science students may not be included in  
23          the costs of operating a primary care center, ex-  
24          cept that salaries and other costs associated  
25          with the delivery of services by residents may be

1 included in such costs as long as such costs are  
2 prorated based on the actual percentage of time  
3 spent by the resident in the primary care  
4 center.

5 (C) ADVISORY COMMITTEE.—(i) The advi-  
6 sory committee referred to in paragraph (2)(I)  
7 shall participate in the development of an appli-  
8 cation for a grant under this section and the  
9 development of any grant renewal application.

10 (ii) The Secretary may not approve the ap-  
11 plication for a grant under this subsection un-  
12 less the application has been approved by the  
13 advisory committee.

14 (4) USE OF GRANTS.—(A) A grant under this  
15 subsection may be used to cover costs associated  
16 with (i) planning, (ii) developing (including mod-  
17 ernization and renovation of space), and (iii) operat-  
18 ing primary care centers.

19 (B) Not more than 25 percent of any grant  
20 may be used for the purposes specified in subpara-  
21 graph (A)(ii).

22 (c) TECHNICAL ASSISTANCE.—The Secretary shall,  
23 upon request, provide technical and other nonfinancial as-  
24 sistance (including fiscal and program management assist-  
25 ance and training in such management) to a community

1 hospital to assist it in developing plans for, and in operat-  
2 ing, a primary care center. Funds appropriated under this  
3 section may be used to carry out the purposes of this sec-  
4 tion.

5 (d) RETENTION OF EARNED INCOME.—The Sec-  
6 retary shall establish, by regulation, a plan to allow pri-  
7 mary care centers to retain earned income from the oper-  
8 ation of the center if the income is used to—

9 (1) expand or improve the services of the  
10 center;

11 (2) expand the population eligible to utilize the  
12 services of the center;

13 (3) make managerial or physical improvements  
14 to the center; or

15 (4) establish a reserve fund for conversion to a  
16 prepaid reimbursement methodology.

17 (e) USE OF APPROPRIATIONS.—To carry out this sec-  
18 tion, there are authorized to be appropriated \$12,000,000  
19 for fiscal year 1996, \$21,000,000 for fiscal year 1997,  
20 \$150,000,000 for fiscal year 1998, \$160,000,000 for fis-  
21 cal year 1999, \$180,000,000 for fiscal year 2000, and  
22 \$190,000,000 for each of fiscal years 2001 through 2004.

1           **Subtitle C—Academic Health**  
2                           **Centers**

3   **SEC. 4201. STUDY OF PAYMENTS FOR MEDICAL EDUCATION**  
4                           **AT SITES OTHER THAN HOSPITALS.**

5           (a) STUDY.—The Secretary of Health and Human  
6 Services shall conduct a study of the feasibility and desir-  
7 ability of making payments to facilities that are not hos-  
8 pitals for the direct and indirect costs of graduate medical  
9 education attributable to residents trained at such facili-  
10 ties. In conducting the study, the Secretary shall evaluate  
11 new payment methodologies—

12               (1) under which each entity which incurs costs  
13               of graduate medical education shall receive reim-  
14               bursement for such costs; and

15               (2) which would encourage the training of pri-  
16               mary care physicians.

17           (b) REPORT.—Not later than 2 years after the date  
18 of the enactment of this Act, the Secretary shall submit  
19 a report to Congress a report on the study conducted  
20 under subsection (a), and shall include in the report such  
21 recommendations as the Secretary considers appropriate.

22   **SEC. 4202. STUDY OF FUNDING NEEDS OF HEALTH PROFES-**  
23                           **SIONS SCHOOLS.**

24           (a) IN GENERAL.—The Secretary shall conduct a  
25 study for the purpose of determining the funding needs

1 of health professions schools, including schools of medicine  
2 and osteopathic medicine, schools of dentistry, and schools  
3 of public health.

4 (b) CONSIDERATION OF CERTAIN COSTS.—In con-  
5 ducting the study under subsection (a), the Secretary shall  
6 also consider the following costs regarding the funding  
7 needs of health professions schools:

8 (1) Uncompensated costs incurred in providing  
9 health care.

10 (2) Costs resulting from reduced productivity  
11 due to teaching responsibilities.

12 (3) Increased costs of caring for the health  
13 needs of patients with severe medical complications.

14 (4) Uncompensated costs incurred by faculty,  
15 residents, and students in providing consultations  
16 for hospitalized patients.

17 (5) Uncompensated costs incurred in conduct-  
18 ing clinical research.

19 (c) CONSIDERATIONS REGARDING ADDITIONAL  
20 FUNDING.—In conducting the study under subsection (a),  
21 the Secretary shall determine the following:

22 (1) Whether the health professions schools in-  
23 volved have a significant need for an increase in the  
24 amount of funds available to the schools.

25 (2) If there is such a need—



1 (A) recommendations regarding the  
2 sources of funds to provide the increase; and

3 (B) recommendations for a methodology  
4 for determining the amount that should be pro-  
5 vided to the schools involved.

6 (d) REPORT TO CONGRESS.—Not later than 18  
7 months after the date of the enactment of this Act, the  
8 Secretary shall submit to the Congress a report describing  
9 the findings and recommendations made in the study.

10 **Subtitle D—United States-Mexico**  
11 **Border Health Commission**

12 **SEC. 4301. AGREEMENT TO ESTABLISH BINATIONAL COM-**  
13 **MISSION.**

14 The President is authorized and encouraged to con-  
15 clude an agreement with Mexico to establish a binational  
16 commission to be known as the United States-Mexico Bor-  
17 der Health Commission.

18 **SEC. 4302. DUTIES.**

19 It should be the duty of the Commission—

20 (1) to conduct a comprehensive needs assess-  
21 ment in the United States-Mexico border area for  
22 the purposes of identifying, evaluating, preventing,  
23 and resolving health problems that affect the general  
24 population of the area;

1           (2) to implement the actions recommended by  
2 the needs assessment by—

3           (A) assisting in the coordination of the ef-  
4 forts of public and private entities to prevent  
5 and resolve such health problems,

6           (B) assisting in the coordination of the ef-  
7 forts of public and private entities to educate  
8 such population concerning such health prob-  
9 lems, and

10          (C) assisting in the development and im-  
11 plementation of programs to prevent and re-  
12 solve such health problems and (where nec-  
13 essary) to educate such population concerning  
14 such health programs; and

15          (3) to formulate recommendations to the Gov-  
16 ernments of the United States and Mexico concern-  
17 ing a fair and reasonable method by which the gov-  
18 ernment of one country would reimburse a public or  
19 private entity in the other country for the cost of a  
20 health care service that the entity furnishes to a citi-  
21 zen of the first country who is unable, through in-  
22 surance or otherwise, to pay for the service.

23 **SEC. 4303. OTHER AUTHORIZED FUNCTIONS.**

24          In addition to the duties described in section 4302,  
25 the Commission should be authorized to perform the fol-

1 lowing additional functions as the Commission determines  
2 to be appropriate:

3           (1) To conduct or sponsor investigations, re-  
4 search, or studies designed to identify, study, and  
5 monitor health problems that affect the general pop-  
6 ulation in the United States-Mexico border area.

7           (2) To provide financial, technical, or adminis-  
8 trative assistance to public or private entities who  
9 act to prevent, resolve, or educate such population  
10 concerning such health problems.

11 **SEC. 4304. MEMBERSHIP.**

12           (a) NUMBER AND APPOINTMENT OF UNITED STATES  
13 SECTION.—The United States section of the Commission  
14 should be composed of 13 members. The section should  
15 consist of the following members:

16           (1) The Secretary of Health and Human Serv-  
17 ices or such individual's delegate.

18           (2) The commissioners of health from the  
19 States of Texas, New Mexico, California, and Ari-  
20 zona or such individuals' delegates.

21           (3) 2 individuals from each of the States of  
22 Texas, New Mexico, California, and Arizona who are  
23 nominated by the chief executive officer of one of  
24 such States and are appointed by the President from  
25 among individuals who have demonstrated ties to

1 community-based organizations and have a dem-  
2 onstrated interest in health issues of the United  
3 States-Mexico border area.

4 (b) COMMISSIONER.—The Commissioner of the Unit-  
5 ed States section of the Commission should be the Sec-  
6 retary of Health and Human Services or such individual's  
7 delegate to the Commission. The Commissioner should be  
8 the leader of the section.

9 **SEC. 4305. REGIONAL OFFICES.**

10 The Commission should establish no fewer than 2 re-  
11 gional border offices in locations selected by the Commis-  
12 sion.

13 **SEC. 4306. REPORTS.**

14 Not later than February 1 of each year that occurs  
15 more than 1 year after the date of the establishment of  
16 the Commission, the Commission should submit an annual  
17 report to both the United States Government and the Gov-  
18 ernment of Mexico regarding all activities of the Commis-  
19 sion during the preceding calendar year.

20 **SEC. 4307. DEFINITIONS.**

21 For purposes of this subtitle:

22 (1) COMMISSION.—The term “Commission”  
23 means the United States-Mexico Border Health  
24 Commission authorized in section 4301.

1           (2) HEALTH PROBLEM.—The term “health  
2       problem” means a disease or medical ailment or an  
3       environmental condition that poses the risk of dis-  
4       ease or medical ailment. The term includes diseases,  
5       ailments, or risks of disease or ailment caused by or  
6       related to environmental factors, control of animals  
7       and rabies, control of insect and rodent vectors, dis-  
8       posal of solid and hazardous waste, and control and  
9       monitoring of air and water quality.

10          (3) UNITED STATES-MEXICO BORDER AREA.—  
11       The term “United States-Mexico border area”  
12       means the area located in the United States and  
13       Mexico within 100 kilometers of the border between  
14       the United States and Mexico.

15                   **TITLE V—HEALTH CARE**  
16                   **QUALITY ENHANCEMENT**

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1       **Subtitle A—Quality Assurance**

2       **SEC. 5001. HEALTH QUALITY ADVISORY COUNCIL.**

3           (a) ESTABLISHMENT.—The Secretary shall provide  
4 for the establishment of an advisory council to be known  
5 as the “Health Quality Advisory Council” (in this subtitle  
6 referred to as the “Council”).

7           (b) DUTIES.—

8               (1) INITIAL MEASURES AND REQUIREMENTS.—

9                   (A) DEVELOPMENT OF QUALITY MEAS-  
10               URES.—The Council shall develop an initial set  
11               of quality measures to be used to assess the  
12               quality of carriers, group health plans, and mul-  
13               tiple employer welfare arrangements. The qual-  
14               ity measures shall include measures that pro-  
15               vide information with respect to such entities on  
16               the following subjects:

17                       (i) Outcomes of care for specified  
18                       medical conditions.

19                       (ii) Health status of enrollees.

20                       (iii) Health promotion activities.

21                       (iv) Prevention of diseases, disorders,  
22                       disabilities, injuries, and other adverse  
23                       health conditions.

24                       (v) Risk management and reduction.

25                       (vi) Consumer satisfaction.

1 (B) RECOMMENDATIONS.—Not later than  
2 the date that is 9 months from the date of the  
3 enactment of this Act, the Council shall rec-  
4 ommend to the Secretary—

5 (i) the initial set of quality measures  
6 developed under subparagraph (A);

7 (ii) a standard set of data to be devel-  
8 oped and collected in a uniform form and  
9 manner by carriers, group health plans,  
10 and multiple employer welfare arrange-  
11 ments in order to permit such a carrier,  
12 plan, or arrangement to assess its quality  
13 using such initial set of measures;

14 (iii) a standard methodology to be  
15 used by such entities to carry out the as-  
16 sessments described in clause (ii);

17 (iv) a standard format to be used by  
18 such entities publicly to report the results  
19 of such assessments; and

20 (v) a schedule for implementing, in  
21 succession—

22 (I) the data development and col-  
23 lection requirements recommended  
24 under clause (ii);

1 (II) the assessment requirements  
2 recommended under clause (iii); and  
3 (III) the reporting requirements  
4 recommended under clause (iv).

5 (2) MODIFYING MEASURES.—The Council shall  
6 make recommendations to the Secretary with respect  
7 to modifying, as additional information with respect  
8 to carriers, group health plans, and multiple em-  
9 ployer welfare arrangements becomes valid and  
10 available, a set of quality measures selected by the  
11 Secretary under section 5002. A recommendation  
12 under the preceding sentence shall be accompanied  
13 by recommendations for modifications to a data set,  
14 assessment methodology, reporting format, or sched-  
15 ule for implementation selected by the Secretary  
16 under such section that the Council determines  
17 would be necessary in order to implement appro-  
18 priately a modification in the set of quality meas-  
19 ures.

20 (c) MEMBERSHIP.—

21 (1) IN GENERAL.—The Council shall, in accord-  
22 ance with this subsection, be composed of appointed  
23 members and ex officio members. All members of the  
24 Council shall be voting members, other than officials



1 designated under paragraph (3) as ex officio mem-  
2 bers of the Council.

3 (2) APPOINTED MEMBERS.—The Secretary  
4 shall appoint to the Council 9 appropriately qualified  
5 individuals who are not officers or employees of the  
6 United States. Members appointed under this para-  
7 graph shall include—

8 (A) individuals distinguished in the field of  
9 health outcomes;

10 (B) representatives of carriers, group  
11 health plans, and multiple employer welfare ar-  
12 rangements;

13 (C) health care providers; and

14 (D) consumers of health care.

15 (3) EX OFFICIO MEMBERS.—The Secretary may  
16 designate as ex officio members of the Council the  
17 Director of the National Institutes of Health, the  
18 Director of the Centers for Disease Control, the Ad-  
19 ministrator of the Health Care Financing Adminis-  
20 tration, the Assistant Secretary of Defense (Health  
21 Affairs), and the Chief Medical Officer of the De-  
22 partment of Veterans Affairs.

23 (d) TERMS.—

1           (1) IN GENERAL.—Except as provided in para-  
2       graph (2), members of the Council appointed under  
3       subsection (c)(2) shall serve for a term of 3 years.

4           (2) STAGGERED ROTATION.—Of the members  
5       first appointed to the Council under subsection  
6       (c)(2), the Secretary shall appoint 3 members to  
7       serve for a term of 3 years, 3 members to serve for  
8       a term of 2 years, and 3 members to serve for a  
9       term of 1 year.

10          (3) SERVICE BEYOND TERM.—A member of the  
11       Council appointed under subsection (c)(2) may con-  
12       tinue to serve after the expiration of the term of the  
13       member until a successor is appointed.

14          (e) VACANCIES.—If a member of the Council ap-  
15       pointed under subsection (c)(2) does not serve the full  
16       term applicable under subsection (d), the individual ap-  
17       pointed to fill the resulting vacancy shall be appointed for  
18       the remainder of the term of the predecessor of the indi-  
19       vidual.

20          (f) CHAIR.—The Secretary shall, from among the  
21       members of the Council appointed under subsection (c)(2),  
22       designate an individual to serve as the chair of the Coun-  
23       cil.

24          (g) MEETINGS.—The Council shall meet at the call  
25       of the chair or the Secretary.

1 (h) COMPENSATION AND REIMBURSEMENT OF EX-  
2 PENSES.—

3 (1) APPOINTED MEMBERS.—Members of the  
4 Council appointed under subsection (c)(2) shall re-  
5 ceive compensation for each day (including travel-  
6 time) engaged in carrying out the duties of the  
7 Council. Such compensation may not be in an  
8 amount in excess of the maximum rate of basic pay  
9 payable under section 5376 of title 5, United States  
10 Code.

11 (2) EX OFFICIO MEMBERS.—Officials des-  
12 ignated under subsection (c)(3) as ex officio mem-  
13 bers of the Council may not receive compensation for  
14 service on the Council in addition to the compensa-  
15 tion otherwise received for duties carried out as offi-  
16 cers of the United States.

17 (i) STAFF.—The Secretary shall provide to the Coun-  
18 cil such staff, information, and other assistance as may  
19 be necessary to carry out the duties of the Council.

20 (j) DURATION.—Notwithstanding section 14(a) of the  
21 Federal Advisory Committee Act, the Council shall con-  
22 tinue in existence until otherwise provided by law.

23 **SEC. 5002. QUALITY ASSESSMENT USING MEASURES.**

24 (a) INITIAL MEASURES AND REQUIREMENTS.—

1           (1) EVALUATION OF RECOMMENDATIONS.—If  
2       the Council makes the recommendations to the Sec-  
3       retary that are described in section 5001(b)(1)(B)  
4       not later than the deadline described in such section,  
5       the Secretary shall evaluate the recommendations to  
6       determine whether they will provide for effective  
7       measurement and reporting of the quality of car-  
8       riers, group health plans, and multiple employer wel-  
9       fare arrangements. The Secretary shall complete  
10      such evaluation not later than the date that is 90  
11      days from the date on which the Secretary receives  
12      the recommendations of the Council.

13          (2) MODIFICATION.—Prior to the initiation of a  
14      rule making under paragraph (3), the Secretary  
15      may, as the Secretary determines appropriate based  
16      on the evaluation under paragraph (1), modify any  
17      quality measure, data set, assessment methodology,  
18      reporting format, or schedule for implementation  
19      recommended by the Council under section  
20      5001(b)(1)(B).

21          (3) RULE MAKING.—After notice and oppor-  
22      tunity for public comment, the Secretary shall pro-  
23      mulgate a rule that—

1           (A) establishes an initial set of quality  
2 measures of the type described in section  
3 5001(b)(1)(A);

4           (B) establishes a standard data set, meth-  
5 odology, reporting format, and an implementa-  
6 tion schedule of the types described in section  
7 5001(b)(1)(B) and requirements on carriers,  
8 group health plans, and multiple employer wel-  
9 fare arrangements in accordance with such  
10 standards and schedule;

11          (C) requires each carrier, group health  
12 plans, and multiple employer welfare arrange-  
13 ment periodically to publish a report, using the  
14 standard reporting format established under  
15 subparagraph (B), and to send the report to  
16 employers, brokers, health plan purchasing or-  
17 ganizations, and consumers in its service area;

18          (D) specifies the amount and nature of the  
19 data that carriers, group health plans, and mul-  
20 tiple employer welfare arrangements shall  
21 transmit under paragraphs (2) and (4) of sub-  
22 section (b) in order to permit States and the  
23 Secretary of Labor to conduct audits under  
24 paragraphs (1) and (4) of such subsection; and

1 (E) specifies the frequency with which, and  
2 the method by which, such data shall be trans-  
3 mitted to States or the Secretary of Labor.

4 (b) COMPLIANCE.—

5 (1) PERIODIC AUDITS.—Each State shall con-  
6 duct periodic audits to evaluate whether carriers  
7 providing health insurance coverage in the State are  
8 complying with the requirements established under  
9 subsection (a). Such audits shall include an assess-  
10 ment of the completeness, accuracy, and validity of  
11 any data developed or collected by a carrier under  
12 such subsection and any report published by such an  
13 entity under such subsection. A State may satisfy  
14 the requirements of this paragraph by entering into  
15 a contract or other agreement with any appropriate  
16 individual or entity.

17 (2) DATA TRANSMISSION.—A carrier providing  
18 health insurance coverage in a State shall transmit  
19 to the State, in accordance with the requirements  
20 promulgated under subsection (a)(3)(E), the data  
21 determined to be necessary by the Secretary under  
22 subsection (a)(3)(D).

23 (3) ENSURING COMPLIANCE.—A State may  
24 take appropriate action to ensure compliance by car-  
25 riers with the requirements of subsection (a) and

1 paragraph (2). Such action may include the imposi-  
2 tion of a penalty on a carrier that transmits incom-  
3 plete, false, or misleading data to the State.

4 (4) APPLICATION TO GROUP HEALTH PLANS  
5 AND MULTIPLE EMPLOYER WELFARE ARRANGE-  
6 MENTS.—

7 (A) AUDITS AND DATA TRANSMISSION.—

8 The Secretary of Labor shall undertake the du-  
9 ties, and may exercise the authorities, of States  
10 that are described in paragraph (1) with respect  
11 to each group health plan, and each multiple  
12 employer welfare arrangement, that does not  
13 provide health coverage through a carrier. Such  
14 a plan or arrangement shall transmit to the  
15 Secretary of Labor, in accordance with the re-  
16 quirements promulgated under subsection  
17 (a)(3)(E), the data determined to be necessary  
18 by the Secretary of Health and Human Services  
19 under subsection (a)(3)(D).

20 (B) ENSURING COMPLIANCE.—For pur-  
21 poses of part 5 of subtitle B of title I of the  
22 Employee Retirement Income Security Act of  
23 1974, the provisions of this section shall be con-  
24 sidered to be provisions of title I of such Act,  
25 but only to the extent that this section applies

1           to group health plans and multiple employer  
2           welfare arrangements that do not provide  
3           health coverage through a carrier.

4           (c) MODIFYING MEASURES.—

5                 (1) IN GENERAL.—The Secretary may modify  
6           any set of quality measures established under sub-  
7           section (a). The Secretary may make any modifica-  
8           tion to a set of data, standard methodology, stand-  
9           ard reporting format, implementation schedule, or  
10          requirement on carriers, group health plans, and  
11          multiple employer welfare arrangements established  
12          under such subsection that the Secretary determines  
13          is necessary to implement appropriately a modifica-  
14          tion in the set of quality measures.

15                (2) PROCEDURE.—Prior to implementing a  
16          modification under paragraph (1), the Secretary  
17          shall—

18                         (A) receive the recommendations of the  
19           Council with respect to the modification;

20                        (B) provide notice and opportunity for  
21           public comment; and

22                        (C) promulgate a rule.

23   **SEC. 5003. DEFINITIONS.**

24          For purposes of this subtitle:



1           (1) The term “carrier” means a carrier (as de-  
2       fined in section 1903(2)) providing health insurance  
3       coverage (as defined in section 1903(7)).

4           (2) The term “multiple employer welfare ar-  
5       rangement” means a multiple employer welfare ar-  
6       rangement (as defined in section 1903(12)) provid-  
7       ing benefits consisting of medical care described in  
8       section 607(1) of the Employee Retirement Income  
9       Security Act of 1974.

## 10   **Subtitle B—Primary Care Provider** 11                           **Education**

### 12   **SEC. 5101. AREA HEALTH EDUCATION CENTERS.**

13       Section 746(i)(1)(A) of the Public Health Service Act  
14   (42 U.S.C. 293j(i)(1)(A)) is amended by striking  
15   “through 1995” and inserting “through 1994 and  
16   \$30,000,000 for each of the fiscal years 1995 through  
17   1999”.

### 18   **SEC. 5102. PUBLIC HEALTH AND PREVENTIVE MEDICINE.**

19       Section 765(a) of the Public Health Service Act (42  
20   U.S.C. 294c(a)) is amended by striking “through 1995”  
21   and inserting “through 1999”.

### 22   **SEC. 5103. FAMILY MEDICINE.**

23       Section 747(d)(1) of the Public Health Service Act  
24   (42 U.S.C. 293k(d)(1)) is amended by striking “through  
25   1995” and inserting “through 1999”.

1 **SEC. 5104. GENERAL INTERNAL MEDICINE AND PEDIAT-**  
 2 **RICS.**

3 Section 748(c) of the Public Health Service Act (42  
 4 U.S.C. 293l(c)) is amended by striking “through 1995”  
 5 and inserting “through 1999”.

6 **SEC. 5105. PHYSICIAN ASSISTANTS.**

7 Section 750(d)(1) of the Public Health Service Act  
 8 (42 U.S.C. 293n(d)(1)) is amended by striking “through  
 9 1995” and inserting “through 1999”.

10 **SEC. 5106. ALLIED HEALTH PROJECT GRANTS AND CON-**  
 11 **TRACTS.**

12 Section 767(d) of the Public Health Service Act (42  
 13 U.S.C. 294e(d)) is amended by striking “through 1995”  
 14 and inserting “through 1999”.

15 **SEC. 5107. NURSE PRACTITIONER AND NURSE MIDWIFE**  
 16 **PROGRAMS.**

17 Section 822(d) of the Public Health Service Act (42  
 18 U.S.C. 296m(d)) is amended by striking “and 1994” and  
 19 inserting “through 1999”.

20 **TITLE VI—MARKET INCENTIVES**  
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**1 Subtitle A—Facilitating Establish-**  
**2 ment of Health Plan Purchasing**  
**3 Organization (HPPOs)**

**4 PART 1—HEALTH PLAN PURCHASING**  
**5 ORGANIZATIONS**

**6 SEC. 6001. ESTABLISHMENT AND ORGANIZATION.**

- 7 (a) IN GENERAL.—Health plan purchasing organiza-
- 8 tions (each in this part referred to as a “purchasing orga-
- 9 nization”) may be established in accordance with this part.
- 10 Each purchasing organization shall be chartered under
- 11 State law and operated as a not-for-profit corporation. A

1 carrier may not form, underwrite, or possess a majority  
2 vote of a purchasing organization, but may administer  
3 such an organization.

4 (b) BOARD OF DIRECTORS.—

5 (1) IN GENERAL.—Each purchasing organiza-  
6 tion shall be governed by a Board of Directors. Such  
7 Board shall initially be appointed under procedures  
8 established by the State in which it operates. Subse-  
9 quently, the Board shall be elected by the members  
10 of the organization in accordance with paragraph  
11 (3). Such Board shall be composed of individuals  
12 who are small employers (or representatives of small  
13 employers), eligible employees of small employers (or  
14 representatives of such employees), and qualifying  
15 individuals in the area in which the organization op-  
16 erates.

17 (2) MEMBERSHIP.—A purchasing organization  
18 shall accept all small employers and eligible employ-  
19 ees and other individuals who are in the individual/  
20 small employer market within the area served by the  
21 organization as members if such employers, employ-  
22 ees, or individuals request such membership.

23 (3) VOTING.—Members of a purchasing organi-  
24 zation shall have voting rights consistent with the

1 rules established under the bylaws governing the or-  
2 ganization.

3 (c) DUTIES OF PURCHASING ORGANIZATIONS.—

4 (1) IN GENERAL.—Subject to paragraph (2),  
5 each purchasing organization shall—

6 (A) market health insurance coverage in  
7 the individual/small group market throughout  
8 the entire area served by the organization;

9 (B) enter into agreements under section  
10 6002 with carriers offering qualified health cov-  
11 erage under this subtitle;

12 (C) enter into agreements with small em-  
13 ployers under section 6003;

14 (D) enroll individuals with carriers offering  
15 qualified health coverage, only in accordance  
16 with section 6004;

17 (E) disseminate quality information under  
18 section 4002; and

19 (F) carry out other functions provided for  
20 under this part.

21 (2) LIMITATION ON ACTIVITIES.—A purchasing  
22 organization shall not—

23 (A) perform any activity (including review,  
24 approval, or enforcement) relating to payment  
25 rates for providers;



1 (B) perform any activity (including certifi-  
2 cation or enforcement) relating to compliance of  
3 carriers (and health coverage provided by car-  
4 riers) with the requirements of subtitle A of  
5 title I;

6 (C) assume financial risk in relation to any  
7 such carrier; or

8 (D) perform other activities identified by  
9 the State as being inconsistent with the per-  
10 formance of its duties under paragraph (1).

11 (3) CHARACTERISTICS OF SERVICE AREA.—

12 (A) IN GENERAL.—A purchasing organiza-  
13 tion need not serve geographic areas that are  
14 contiguous, but the geographic boundaries of  
15 such areas shall be consistent with the bound-  
16 aries established under section 1021 for fair  
17 rating areas.

18 (B) SERVICE OF ENTIRE METROPOLITAN  
19 STATISTICAL AREA.—If a purchasing organiza-  
20 tion serves a part of a metropolitan statistical  
21 area the organization shall serve the entire  
22 area.

23 (d) ESTABLISHMENT NOT REQUIRED.—Nothing in  
24 this section shall be construed as requiring—

1           (1) that a purchasing organization be estab-  
2           lished in each area of a State in which it operates;  
3           and

4           (2) that there be only one purchasing organiza-  
5           tion established with respect to any area.

6 **SEC. 6002. AGREEMENTS TO OFFER QUALIFIED HEALTH**  
7 **COVERAGE.**

8           (a) AGREEMENTS.—

9           (1) IN GENERAL.—Except as provided in para-  
10          graph (3), each purchasing organization for an area  
11          shall enter into an agreement under this section with  
12          each carrier that desires to make available qualified  
13          health coverage through the purchasing organization  
14          (consistent with any procedures established by the  
15          State).

16          (2) TERMINATION OF AGREEMENT.—An agree-  
17          ment under paragraph (1) shall remain in effect for  
18          a 12-month period, except that the purchasing orga-  
19          nization may terminate an agreement under para-  
20          graph (1) if the carrier's license or certification  
21          under State law is terminated or for other good  
22          cause shown.

23          (3) LIMITATION ON RENEWAL OF AGREE-  
24          MENTS.—Subsequent to the 12-month period de-

1 scribed in paragraph (2), a purchasing organization  
2 may—

3 (A) refuse to enter into a subsequent  
4 agreement with a carrier if the organization de-  
5 termines that the number of enrollees or the  
6 premium for coverage is too low, and

7 (B) if a previous agreement with a carrier  
8 was terminated for good cause and the organi-  
9 zation determines appropriate actions have not  
10 been taken to correct the problems, refuse to  
11 enter into a subsequent agreement with the car-  
12 rier.

13 (b) RECEIPT OF PREMIUMS ON BEHALF OF CAR-  
14 RIERS.—

15 (1) IN GENERAL.—Under an agreement under  
16 this section between a purchasing organization and  
17 a carrier—

18 (A) premiums shall be payable, and

19 (B) payment of premiums may be made by  
20 individuals (or employers on their behalf) di-  
21 rectly to the purchasing organization for the  
22 benefit of the carrier.

23 (2) TIMING OF PAYMENT OF PREMIUMS.—Pre-  
24 miums may be payable on a monthly basis (or, at  
25 the option of an eligible employee or individual, on

1 a quarterly basis). The purchasing organization may  
2 provide for reasonable penalties and grace periods  
3 for late payment.

4 (3) CARRIERS RETAIN RISK OF  
5 NONPAYMENT.—Nothing in this subsection shall be  
6 construed as placing upon a purchasing organization  
7 any risk associated with the failure of individuals  
8 and employers to make prompt payment of pre-  
9 miums (other than the portion of the premium rep-  
10 resenting the purchasing organization administrative  
11 fee under section 6005). Each small employer and  
12 qualifying individual who enrolls with a carrier pro-  
13 viding qualified health coverage through the pur-  
14 chasing organization is liable to the carrier for pre-  
15 miums.

16 (c) FORWARDING OF PREMIUMS.—

17 (1) IN GENERAL.—If, under an agreement  
18 under subsection (a), premium payments for quali-  
19 fied health coverage are made to the purchasing or-  
20 ganization, the purchasing organization shall for-  
21 ward to the carrier the amount of the premiums.

22 (2) PAYMENTS.—Payments shall be made by  
23 the purchasing organization under this subsection  
24 within a period of days (specified by the Secretary  
25 and not to exceed 7 days) after receipt of the pre-

1 mium from the small employer of the eligible em-  
2 ployee or the qualifying individual, as the case may  
3 be.

4 (d) PAYMENT OF COMMISSIONS.—

5 (1) IN GENERAL.—Subject to paragraph (2),  
6 nothing in this part shall be construed to preclude  
7 a carrier from paying a commission or other remu-  
8 nation in connection with the purchase of health  
9 care coverage by individuals or groups, consistent  
10 with State law.

11 (2) LIMITATION ON VARIATION.—A carrier may  
12 not vary such compensation or remuneration based,  
13 directly or indirectly, on the anticipated or actual  
14 claims experience associated with the group or indi-  
15 viduals purchasing health care coverage.

16 **SEC. 6003. PROVISION OF INFORMATION.**

17 (a) IN GENERAL.—Each purchasing organization for  
18 an area shall make available to small employers that em-  
19 ploy individuals in the area and to qualifying individuals  
20 who reside in the area—

21 (1) information provided to the purchasing or-  
22 ganization by the State or carriers, and

23 (2) the opportunity to enter into an agreement  
24 with the organization for the purchase of qualified  
25 health coverage.

1       (b) FORWARDING INFORMATION AND PAYROLL DE-  
2 Ductions.—As part of an agreement entered into under  
3 this section, a small employer shall forward the informa-  
4 tion and make the payroll deductions required under sec-  
5 tion 1201(a).

6 **SEC. 6004. ENROLLING ELIGIBLE EMPLOYEES AND QUALI-**  
7 **FYING INDIVIDUALS FOR QUALIFIED HEALTH**  
8 **COVERAGE THROUGH A PURCHASING ORGA-**  
9 **NIZATION.**

10       A purchasing organization shall offer, on behalf of  
11 each carrier with which an agreement was entered into  
12 under section 6002 and in accordance with the enrollment  
13 procedures of such carriers and the enrollment periods  
14 provided under 1005, enrollment for the coverage only to  
15 individuals in the individual/small group market in the  
16 area served by the purchasing organization. Each purchas-  
17 ing organization shall coordinate annual open enrollment  
18 periods (described in section 1005(c)) of all carriers  
19 through which coverage is offered by the organization so  
20 that there is one common annual open enrollment period  
21 for all such carriers with respect to each individual en-  
22 rolled for coverage through the organization. Nothing in  
23 this section shall preclude a purchasing organization from  
24 having different common annual open enrollment periods  
25 for different individuals.

1 **SEC. 6005. RESTRICTION ON CHARGES.**

2 (a) IN GENERAL.—A purchasing organization may  
3 impose an administrative fee with respect to an eligible  
4 employee or qualifying individual enrolled for qualified  
5 health coverage offered through the purchasing organiza-  
6 tion.

7 (b) FEE.—A purchasing organization that elects to  
8 impose a fee under subsection (a) shall ensure that such  
9 fee is set as a percentage of the premium for each such  
10 coverage option, is imposed uniformly with respect to all  
11 coverage options offered through the organization, and is  
12 disclosed explicitly as an addition to the premium.

13 **SEC. 6006. STATE REPORT ON ESTABLISHMENT OF**  
14 **PURCHASING ORGANIZATIONS.**

15 (a) IN GENERAL.—Not later than January 1, 2000,  
16 each State shall conduct a review of access of residents  
17 of the State who are not employees of large employers or  
18 medicare beneficiaries to obtaining standard health insur-  
19 ance coverage through a purchasing organization.

20 (b) RESPONSE.—If the State determines, based on  
21 such review, that such residents are unable to obtain such  
22 coverage through such an organization, the State shall  
23 take such actions as the State determines appropriate to  
24 ensure public or private entities provide access to such an  
25 organization by such residents.

1 **PART 2—ENCOURAGEMENT OF MULTIPLE**  
2 **EMPLOYER ARRANGEMENTS PROVIDING**  
3 **BASIC HEALTH BENEFITS**

4 **SEC. 6011. ELIMINATING COMMONALITY OF INTEREST OR**  
5 **GEOGRAPHIC LOCATION REQUIREMENT FOR**  
6 **TAX EXEMPT TRUST STATUS.**

7 (a) IN GENERAL.—Paragraph (9) of section 501(c)  
8 of the Internal Revenue Code of 1986 (relating to exempt  
9 organizations) is amended—

10 (1) by inserting “(A)” after “(9)”; and

11 (2) by adding at the end the following:

12 “(B) Any determination of whether a certified  
13 multiple employer health plan (as defined in section  
14 701(9) of the Employee Retirement Income Security  
15 Act of 1974), a multiple employer welfare arrange-  
16 ment which is fully insured, or a plan described in  
17 clause (ii) or (iii) of section 3(40)(A) of such Act is  
18 a voluntary employees’ beneficiary association meet-  
19 ing the requirements of this paragraph shall be  
20 made without regard to any determination of com-  
21 monality of interest or geographic location.”.

22 (b) EFFECTIVE DATE.—The amendments made by  
23 subsection (a) shall apply with respect to determinations  
24 made on or after the date of the enactment of this Act.



1 **PART 3—TAX EXEMPTION FOR HIGH RISK POOLS**

2 **SEC. 6021. TAX EXEMPTION FOR HIGH RISK INSURANCE**  
3 **POOLS.**

4 (a) IN GENERAL.—Subsection (c) of section 501 of  
5 the Internal Revenue Code of 1986 (relating to list of ex-  
6 empt organizations) is amended by adding at the end the  
7 following new paragraph:

8 “(27) In the case of taxable years beginning be-  
9 fore January 1, 1997, any corporation, association,  
10 or similar legal entity which is created by any State  
11 or political subdivision thereof to establish a risk  
12 pool to provide health insurance coverage to any per-  
13 son unable to obtain health insurance coverage in  
14 the private insurance market because of health con-  
15 ditions and no part of the net earnings of which in-  
16 ures to the benefit of any private shareholder, mem-  
17 ber, or individual.”

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) shall apply to taxable years beginning after  
20 December 31, 1989.

21 **Subtitle B—Preemption of State**  
22 **Benefit Mandates and Anti-Man-**  
23 **aged Care Laws**

24 **SEC. 6101. PREEMPTION FROM STATE BENEFIT MANDATES.**

25 Effective as of January 1, 1997, no State shall estab-  
26 lish or enforce any law or regulation that—

1           (1) requires the offering, as part of health in-  
2           surance coverage, of any services, category of care,  
3           or services of any class or type of provider, except  
4           as provided in section 1013; or

5           (2) specifies the individuals to be provided  
6           health insurance coverage or the duration of such  
7           coverage.

8   **SEC. 6102. PREEMPTION OF STATE LAW RESTRICTIONS ON**  
9                           **MANAGED CARE ARRANGEMENTS.**

10          (a) LIMITATION ON RESTRICTIONS ON NETWORK  
11   PLANS.—Effective as of January 1, 1997—

12           (1) a State may not prohibit or limit a carrier  
13           or group health plan providing health coverage from  
14           including incentives for enrollees to use the services  
15           of participating providers;

16           (2) a State may not prohibit or limit such a  
17           carrier or plan from limiting coverage of services to  
18           those provided by a participating provider, except as  
19           provided in section 1013;

20           (3) a State may not prohibit or limit the nego-  
21           tiation of rates and forms of payments for providers  
22           by such a carrier or plan with respect to health  
23           coverage;

1           (4) a State may not prohibit or limit such a  
2       carrier or plan from limiting the number of partici-  
3       pating providers;

4           (5) a State may not prohibit or limit such a  
5       carrier or plan from requiring that services be pro-  
6       vided (or authorized) by a practitioner selected by  
7       the enrollee from a list of available participating pro-  
8       viders or, except as provided in section 1011(e),  
9       from requiring enrollees to obtain referral in order  
10      to have coverage for treatment by a specialist or  
11      health institution; and

12          (6) a State may not prohibit or limit the  
13      corporate practice of medicine.

14      (b) DEFINITIONS.—In this section:

15          (1) MANAGED CARE COVERAGE.—The term  
16      “managed care coverage” means health coverage to  
17      the extent the coverage is provided through a man-  
18      aged care arrangement (as defined in section  
19      1903(11)(A)) that meets the applicable requirements  
20      of such section.

21          (2) PARTICIPATING PROVIDER.—The term  
22      “participating provider” means an entity or individ-  
23      ual which provides, sells, or leases health care serv-  
24      ices as part of a provider network (as defined in sec-  
25      tion 1903(11)(B)).

1 (c) REFERENCE TO STANDARDS FOR MANAGED  
2 CARE ARRANGEMENTS.—For requirements relating to  
3 managed care arrangements, see section 1011.

4 **SEC. 6103. PREEMPTION OF STATE LAWS RESTRICTING UTI-**  
5 **LIZATION REVIEW PROGRAMS.**

6 (a) IN GENERAL.—Effective January 1, 1997, no  
7 State law or regulation shall prohibit or regulate activities  
8 under a utilization review program (as defined in sub-  
9 section (b)).

10 (b) UTILIZATION REVIEW PROGRAM DEFINED.—In  
11 this section, the term “utilization review program” means  
12 a system of reviewing the medical necessity and appro-  
13 priateness of patient services (which may include inpatient  
14 and outpatient services) using specified guidelines. Such  
15 a system may include preadmission certification, the appli-  
16 cation of practice guidelines, continued stay review, dis-  
17 charge planning, preauthorization of ambulatory proce-  
18 dures, and retrospective review.

19 (c) EXEMPTION OF LAWS PREVENTING DENIAL OF  
20 LIFESAVING MEDICAL TREATMENT PENDING TRANSFER  
21 TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this  
22 subtitle shall be construed to invalidate any State law that  
23 has the effect of preventing involuntary denial of life-pre-  
24 serving medical treatment when such denial would cause  
25 the involuntary death of the patient pending transfer of

1 the patient to a health care provider willing to provide  
2 such treatment.

3 **SEC. 6104. PROHIBITION OF PROVISIONS PROHIBITING EM-**  
4 **LOYER GROUPS FROM PURCHASING**  
5 **HEALTH INSURANCE.**

6 No provision of State or local law shall apply that  
7 prohibits 2 or more employers from obtaining coverage  
8 that is fully insured (within the meaning of section 701(8)  
9 of the Employee Retirement Income Security Act of 1974,  
10 as added by section 1401(a) of this Act) under a multiple  
11 employer health plan.

12 **SEC. 6105. PREEMPTION RELATING TO DIFFERENT INSUR-**  
13 **ANCE STANDARDS.**

14 A State may not establish or enforce standards for  
15 health insurance coverage made available in the individual  
16 and small group markets that are different from the  
17 standards established under title I.

18 **SEC. 6106. GAO STUDY ON MANAGED CARE.**

19 (a) IN GENERAL.—The Comptroller General shall  
20 conduct a study of the benefits and cost effectiveness of  
21 the use of managed care in the delivery of health services.

22 (b) REPORT.—By not later than 4 years after the  
23 date of the enactment of this Act, the Comptroller General  
24 shall submit a report to Congress on the study conducted

1 under subsection (a) and shall include in the report such  
2 recommendations as may be appropriate.

## 3 **Subtitle C—Malpractice Reform**

### 4 **PART 1—UNIFORM STANDARDS FOR** 5 **MALPRACTICE CLAIMS**

#### 6 **SEC. 6201. APPLICABILITY.**

7 Except as provided in section 6221, this part shall  
8 apply to any medical malpractice liability action brought  
9 in a Federal or State court, and to any medical mal-  
10 practice claim subject to an alternative dispute resolution  
11 system, that is initiated on or after January 1, 1996.

#### 12 **SEC. 6202. REQUIREMENT FOR INITIAL RESOLUTION OF AC-** 13 **TION THROUGH ALTERNATIVE DISPUTE RES-** 14 **OLUTION.**

##### 15 (a) IN GENERAL.—

16 (1) STATE CASES.—A medical malpractice li-  
17 ability action may not be brought in any State court  
18 during a calendar year unless the medical mal-  
19 practice liability claim that is the subject of the ac-  
20 tion has been initially resolved under an alternative  
21 dispute resolution system certified for the year by  
22 the Secretary under section 6212(a), or, in the case  
23 of a State in which such a system is not in effect  
24 for the year, under the alternative Federal system  
25 established under section 6222(b).

1           (2) FEDERAL DIVERSITY ACTIONS.—A medical  
2 malpractice liability action may not be brought in  
3 any Federal court under section 1332 of title 28,  
4 United States Code, during a calendar year unless  
5 the medical malpractice liability claim that is the  
6 subject of the action has been initially resolved  
7 under the alternative dispute resolution system re-  
8 ferred to in paragraph (1) that applied in the State  
9 whose law applies in such action.

10           (3) CLAIMS AGAINST UNITED STATES.—

11           (A) ESTABLISHMENT OF PROCESS FOR  
12 CLAIMS.—The Attorney General shall establish  
13 an alternative dispute resolution process for the  
14 resolution of tort claims consisting of medical  
15 malpractice liability claims brought against the  
16 United States under chapter 171 of title 28,  
17 United States Code. Under such process, the  
18 resolution of a claim shall occur after the com-  
19 pletion of the administrative claim process ap-  
20 plicable to the claim under section 2675 of such  
21 title.

22           (B) REQUIREMENT FOR INITIAL RESOLU-  
23 TION UNDER PROCESS.—A medical malpractice  
24 liability action based on a medical malpractice  
25 liability claim described in subparagraph (A)

1           may not be brought in any Federal court unless  
2           the claim has been initially resolved under the  
3           alternative dispute resolution process estab-  
4           lished by the Attorney General under such sub-  
5           paragraph.

6           (b) INITIAL RESOLUTION OF CLAIMS UNDER  
7   ADR.—For purposes of subsection (a), an action is “ini-  
8   tially resolved” under an alternative dispute resolution  
9   system if—

10           (1) the ADR reaches a decision on whether the  
11          defendant is liable to the plaintiff for damages; and

12           (2) if the ADR determines that the defendant  
13          is liable, the ADR reaches a decision on the amount  
14          of damages assessed against the defendant.

15          (c) PROCEDURES FOR FILING ACTIONS.—

16           (1) NOTICE OF INTENT TO CONTEST DECI-  
17          SION.—Not later than 60 days after a decision is is-  
18          sued with respect to a medical malpractice liability  
19          claim under an alternative dispute resolution system,  
20          each party affected by the decision shall submit a  
21          sealed statement to a court of competent jurisdiction  
22          indicating whether or not the party intends to con-  
23          test the decision.



1           (2) DEADLINE FOR FILING ACTION.—A medical  
2       malpractice liability action may not be brought by a  
3       party unless—

4           (A) the party has filed the notice of intent  
5       required by paragraph (1); and

6           (B) the party files the action in a court of  
7       competent jurisdiction not later than 90 days  
8       after the decision resolving the medical mal-  
9       practice liability claim that is the subject of the  
10      action is issued under the applicable alternative  
11      dispute resolution system.

12          (3) COURT OF COMPETENT JURISDICTION.—  
13      For purposes of this subsection, the term “court of  
14      competent jurisdiction” means—

15           (A) with respect to actions filed in a State  
16      court, the appropriate State trial court; and

17           (B) with respect to actions filed in a Fed-  
18      eral court, the appropriate United States dis-  
19      trict court.

20          (d) LEGAL EFFECT OF UNCONTESTED ADR DECI-  
21      SION.—The decision reached under an alternative dispute  
22      resolution system shall, for purposes of enforcement by a  
23      court of competent jurisdiction, have the same status in  
24      the court as the verdict of a medical malpractice liability  
25      action adjudicated in a State or Federal trial court. The

1 previous sentence shall not apply to a decision that is con-  
2 tested by a party affected by the decision pursuant to sub-  
3 section (c)(1).

4 **SEC. 6203. OPTIONAL APPLICATION OF PRACTICE GUIDE-**  
5 **LINES.**

6 (a) DEVELOPMENT AND CERTIFICATION OF GUIDE-  
7 LINES.—Each State may develop, for certification by the  
8 Secretary, a set of specialty clinical practice guidelines,  
9 based on recommended guidelines from national specialty  
10 societies, to be updated annually. In the absence of rec-  
11 ommended guidelines from such societies, each State may  
12 develop such guidelines based on such criteria as the State  
13 considers appropriate (including based on recommended  
14 guidelines developed by the Agency for Health Care Policy  
15 and Research).

16 (b) PROVISION OF HEALTH CARE UNDER GUIDE-  
17 LINES.—Notwithstanding any other provision of law, in  
18 any medical malpractice liability action arising from the  
19 conduct of a health care provider or health care profes-  
20 sional, if such conduct was in accordance with a guideline  
21 developed by the State in which the conduct occurred and  
22 certified by the Secretary under subsection (a), the guide-  
23 line—

1           (1) may be introduced by any party to the ac-  
2           tion (including a health care provider, health care  
3           professional, or patient); and

4           (2) if introduced, shall establish a rebuttable  
5           presumption that the conduct was in accordance  
6           with the appropriate standard of medical care, which  
7           may only be overcome by the presentation of clear  
8           and convincing evidence on behalf of the party  
9           against whom the presumption operates.

10 **SEC. 6204. TREATMENT OF NONECONOMIC AND PUNITIVE**  
11 **DAMAGES.**

12           (a) LIMITATION ON NONECONOMIC DAMAGES.—The  
13           total amount of noneconomic damages that may be award-  
14           ed to a claimant and the members of the claimant's family  
15           for losses resulting from the injury which is the subject  
16           of a medical malpractice liability action may not exceed  
17           \$250,000, regardless of the number of parties against  
18           whom the action is brought or the number of actions  
19           brought with respect to the injury.

20           (b) NO AWARD OF PUNITIVE DAMAGES AGAINST  
21           MANUFACTURER OF MEDICAL PRODUCT.—In the case of  
22           a medical malpractice liability action in which the plaintiff  
23           alleges a claim against the manufacturer of a medical  
24           product, no punitive or exemplary damages may be award-  
25           ed against such manufacturer.

1       (c) JOINT AND SEVERAL LIABILITY FOR NON-  
2 ECONOMIC DAMAGES.—The liability of each defendant for  
3 noneconomic damages shall be several only and shall not  
4 be joint, and each defendant shall be liable only for the  
5 amount of noneconomic damages allocated to the defend-  
6 ant in direct proportion to the defendant's percentage of  
7 responsibility (as determined by the trier of fact).

8       (d) USE OF PUNITIVE DAMAGE AWARDS FOR OPER-  
9 ATION OF ADR SYSTEMS IN STATES.—

10           (1) IN GENERAL.—The total amount of any pu-  
11 nitive damages awarded in a medical malpractice li-  
12 ability action shall be paid to the State in which the  
13 action is brought (or, in a case brought in Federal  
14 court, in the State in which the health care services  
15 that caused the injury that is the subject of the ac-  
16 tion were provided), and shall be used by the State  
17 solely to implement and operate the State alternative  
18 dispute resolution system certified by the Secretary  
19 under section 6222 (except as provided in paragraph  
20 (2)).

21           (2) USE OF REMAINING AMOUNTS FOR PRO-  
22 VIDER LICENSING AND DISCIPLINARY ACTIVITIES.—  
23 If the amount of punitive damages paid to a State  
24 under paragraph (1) for a year is greater than the  
25 State's costs of implementing and operating the

1 State alternative dispute resolution system during  
2 the year, the balance of such punitive damages paid  
3 to the State shall be used solely to carry out activi-  
4 ties to assure the safety and quality of health care  
5 services provided in the State, including (but not  
6 limited to)—

7 (A) licensing or certifying health care pro-  
8 fessionals and health care providers in the  
9 State; and

10 (B) carrying out programs to reduce mal-  
11 practice-related costs for providers volunteering  
12 to provide services in medically underserved  
13 areas.

14 (3) MAINTENANCE OF EFFORT.—A State shall  
15 use any amounts paid pursuant to paragraph (1) to  
16 supplement and not to replace amounts spent by the  
17 State for implementing and operating the State al-  
18 ternative dispute resolution system or carrying out  
19 the activities described in paragraph (2).

20 **SEC. 6205. PERIODIC PAYMENTS FOR FUTURE LOSSES.**

21 (a) IN GENERAL.—In any medical malpractice liabil-  
22 ity action in which the damages awarded for future eco-  
23 nomic loss exceeds \$100,000, a defendant may not be re-  
24 quired to pay such damages in a single, lump-sum pay-  
25 ment, but may be permitted to make such payments on

1 a periodic basis. The periods for such payments shall be  
2 determined by the court, based upon projections of when  
3 such expenses are likely to be incurred.

4 (b) WAIVER.—A court may waive the application of  
5 subsection (a) with respect to a defendant if the court de-  
6 termines that it is not in the best interests of the plaintiff  
7 to receive payments for damages on such a periodic basis.

8 **SEC. 6206. TREATMENT OF ATTORNEY'S FEES AND OTHER**  
9 **COSTS.**

10 (a) REQUIRING PARTY CONTESTING ADR RULING  
11 TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

12 (1) IN GENERAL.—The court in a medical mal-  
13 practice liability action shall require the party that  
14 (pursuant to section 6202(c)(1)) contested the ruling  
15 of the alternative dispute resolution system with re-  
16 spect to the medical malpractice liability claim that  
17 is the subject of the action to pay to the opposing  
18 party the costs incurred by the opposing party under  
19 the action, including attorney's fees, fees paid to ex-  
20 pert witnesses, and other litigation expenses (but not  
21 including court costs, filing fees, or other expenses  
22 paid directly by the party to the court, or any fees  
23 or costs associated with the resolution of the claim  
24 under the alternative dispute resolution system), but  
25 only if—

1           (A) in the case of an action in which the  
2           party that contested the ruling is the claimant,  
3           the amount of damages awarded to the party  
4           under the action is less than the amount of  
5           damages awarded to the party under the ADR  
6           system; and

7           (B) in the case of an action in which the  
8           party that contested the ruling is the defendant,  
9           the amount of damages assessed against the  
10          party under the action is greater than the  
11          amount of damages assessed under the ADR  
12          system.

13          (2) EXCEPTIONS.—Paragraph (1) shall not  
14          apply if—

15                (A) the party contesting the ruling made  
16                under the previous alternative dispute resolu-  
17                tion system shows that—

18                      (i) the ruling was procured by corrup-  
19                      tion, fraud, or undue means,

20                      (ii) there was partiality or corruption  
21                      under the system,

22                      (iii) there was other misconduct under  
23                      the system that materially prejudiced the  
24                      party's rights, or

1 (iv) the ruling was based on an error  
2 of law;

3 (B) the party contesting the ruling made  
4 under the alternative dispute resolution system  
5 presents new evidence before the trier of fact  
6 that was not available for presentation under  
7 the ADR system;

8 (C) the medical malpractice liability action  
9 raised a novel issue of law; or

10 (D) the court finds that the application of  
11 such paragraph to a party would constitute an  
12 undue hardship, and issues an order waiving or  
13 modifying the application of such paragraph  
14 that specifies the grounds for the court's deci-  
15 sion.

16 (3) LIMIT ON ATTORNEYS' FEES PAID.—Attor-  
17 neys' fees that are required to be paid under para-  
18 graph (1) by the contesting party shall not exceed  
19 the amount of the attorneys' fees incurred by the  
20 contesting party in the action. If the attorneys' fees  
21 of the contesting party are based on a contingency  
22 fee agreement, the amount of attorneys' fees for  
23 purposes of the preceding sentence shall not exceed  
24 the reasonable value of those services.



1           (4) RECORDS.—In order to receive attorneys’  
2       fees under paragraph (1), counsel of record in the  
3       medical malpractice liability action involved shall  
4       maintain accurate, complete records of hours worked  
5       on the action, regardless of the fee arrangement  
6       with the client involved.

7       (b) CONTINGENCY FEE DEFINED.—As used in this  
8       section, the term “contingency fee” means any fee for pro-  
9       fessional legal services which is, in whole or in part, con-  
10      tingent upon the recovery of any amount of damages,  
11      whether through judgment or settlement.

12   **SEC. 6207. UNIFORM STATUTE OF LIMITATIONS.**

13      (a) IN GENERAL.—Except as provided in subsection  
14      (b), no medical malpractice claim may be initiated after  
15      the expiration of the 2-year period that begins on the date  
16      on which the alleged injury that is the subject of such  
17      claim was discovered, but in no event may such a claim  
18      be initiated after the expiration of the 4-year period that  
19      begins on the date on which the alleged injury that is the  
20      subject of such claim occurred.

21      (b) EXCEPTION FOR MINORS.—In the case of an al-  
22      leged injury suffered by a minor who has not attained 6  
23      years of age, a medical malpractice claim may not be initi-  
24      ated after the expiration of the 2-year period that begins  
25      on the date on which the alleged injury that is the subject

1 of such claim was discovered or should reasonably have  
2 been discovered, but in no event may such a claim be initi-  
3 ated after the date on which the minor attains 12 years  
4 of age.

5 **SEC. 6208. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**  
6 **SERVICES.**

7 (a) IN GENERAL.—In the case of a medical mal-  
8 practice claim relating to services provided during labor  
9 or the delivery of a baby, if the health care professional  
10 or health care provider against whom the claim is brought  
11 did not previously treat the claimant for the pregnancy,  
12 the trier of fact may not find that such professional or  
13 provider committed malpractice and may not assess dam-  
14 ages against such professional or provider unless the mal-  
15 practice is proven by clear and convincing evidence.

16 (b) APPLICABILITY TO GROUP PRACTICES OR  
17 AGREEMENTS AMONG PROVIDERS.—For purposes of sub-  
18 section (a), a health care professional shall be considered  
19 to have previously treated an individual for a pregnancy  
20 if the professional is a member of a group practice whose  
21 members previously treated the individual for the preg-  
22 nancy or is providing services to the individual during  
23 labor or the delivery of a baby pursuant to an agreement  
24 with another professional.

1 **SEC. 6209. JURISDICTION OF FEDERAL COURTS.**

2       Nothing in this part shall be construed to establish  
3 any jurisdiction over any medical malpractice liability ac-  
4 tion in the district courts of the United States on the basis  
5 of sections 1331 or 1337 of title 28, United States Code.

6 **SEC. 6210. PREEMPTION.**

7       (a) IN GENERAL.—The provisions of this part shall  
8 preempt any State law to the extent such law is inconsist-  
9 ent with such provisions, except that the provisions of this  
10 part shall not preempt any State law that provides for de-  
11 fenses or places limitations on a person’s liability in addi-  
12 tion to those contained in this part, places greater limita-  
13 tions on the amount of attorneys’ fees that can be col-  
14 lected, or otherwise imposes greater restrictions than those  
15 provided in this part.

16       (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
17 OF LAW OR VENUE.—Nothing in this part shall be con-  
18 strued to—

19           (1) waive or affect any defense of sovereign im-  
20 munity asserted by any State under any provision of  
21 law;

22           (2) waive or affect any defense of sovereign im-  
23 munity asserted by the United States;

24           (3) affect the applicability of any provision of  
25 the Foreign Sovereign Immunities Act of 1976;

1           (4) preempt State choice-of-law rules with re-  
2           spect to claims brought by a foreign nation or a citi-  
3           zen of a foreign nation; or

4           (5) affect the right of any court to transfer  
5           venue or to apply the law of a foreign nation or to  
6           dismiss a claim of a foreign nation or of a citizen  
7           of a foreign nation on the ground in inconvenient  
8           forum.

9   **PART 2—REQUIREMENTS FOR STATE ALTER-**  
10   **NATIVE DISPUTE RESOLUTION SYSTEMS**  
11   **(ADR)**

12   **SEC. 6221. BASIC REQUIREMENTS.**

13           (a) IN GENERAL.—A State’s alternative dispute reso-  
14           lution system meets the requirements of this section if the  
15           system—

16           (1) applies to all medical malpractice liability  
17           claims under the jurisdiction of the courts of that  
18           State;

19           (2) requires that a written opinion resolving the  
20           dispute be issued not later than 6 months after the  
21           date by which each party against whom the claim is  
22           filed has received notice of the claim (other than in  
23           exceptional cases for which a longer period is re-  
24           quired for the issuance of such an opinion), and that  
25           the opinion contain—

1 (A) findings of fact relating to the dispute,  
2 and

3 (B) a description of the costs incurred in  
4 resolving the dispute under the system (includ-  
5 ing any fees paid to the individuals hearing and  
6 resolving the claim), together with an appro-  
7 priate assessment of the costs against any of  
8 the parties;

9 (3) requires individuals who hear and resolve  
10 claims under the system to meet such qualifications  
11 as the State may require (in accordance with regula-  
12 tions of the Secretary);

13 (4) is approved by the State or by local govern-  
14 ments in the State;

15 (5) with respect to a State system that consists  
16 of multiple dispute resolution procedures—

17 (A) permits the parties to a dispute to se-  
18 lect the procedure to be used for the resolution  
19 of the dispute under the system, and

20 (B) if the parties do not agree on the pro-  
21 cedure to be used for the resolution of the dis-  
22 pute, assigns a particular procedure to the  
23 parties;

24 (6) provides for the transmittal to the State  
25 agency responsible for monitoring or disciplining

1 health care professionals and health care providers  
2 of any findings made under the system that such a  
3 professional or provider committed malpractice, un-  
4 less, during the 90-day period beginning on the date  
5 the system resolves the claim against the profes-  
6 sional or provider, the professional or provider  
7 brings an action contesting the decision made under  
8 the system; and

9 (7) provides for the regular transmittal to the  
10 Administrator for Health Care Policy and Research  
11 of information on disputes resolved under the sys-  
12 tem, in a manner that assures that the identity of  
13 the parties to a dispute shall not be revealed.

14 (b) APPLICATION OF MALPRACTICE LIABILITY  
15 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—  
16 The provisions of part 1 (other than section 6202) shall  
17 apply with respect to claims brought under a State alter-  
18 native dispute resolution system or the alternative Federal  
19 system in the same manner as such provisions apply with  
20 respect to medical malpractice liability actions brought in  
21 the State.

22 **SEC. 6222. CERTIFICATION OF STATE SYSTEMS; APPLICA-**  
23 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

24 (a) CERTIFICATION.—

1           (1) IN GENERAL.—Not later than October 1 of  
2       each year (beginning with 1995), the Secretary, in  
3       consultation with the Attorney General, shall deter-  
4       mine whether a State’s alternative dispute resolution  
5       system meets the requirements of this part for the  
6       following calendar year.

7           (2) BASIS FOR CERTIFICATION.—The Secretary  
8       shall certify a State’s alternative dispute resolution  
9       system under this subsection for a calendar year if  
10      the Secretary determines under paragraph (1) that  
11      the system meets the requirements of section 6221,  
12      including the requirement described in section 6204  
13      that punitive damages awarded under the system are  
14      paid to the State for the uses described in such  
15      section.

16      (b) APPLICABILITY OF ALTERNATIVE FEDERAL  
17      SYSTEM.—

18           (1) ESTABLISHMENT AND APPLICABILITY.—  
19      Not later than October 1, 1995, the Secretary, in  
20      consultation with the Attorney General, shall estab-  
21      lish by rule an alternative Federal ADR system for  
22      the resolution of medical malpractice liability claims  
23      during a calendar year in States that do not have  
24      in effect an alternative dispute resolution system  
25      certified under subsection (a) for the year.

1           (2) REQUIREMENTS FOR SYSTEM.—Under the  
2           alternative Federal ADR system established under  
3           paragraph (1)—

4                   (A) paragraphs (1), (2), (6), and (7) of  
5                   section 6221(a) shall apply to claims brought  
6                   under the system;

7                   (B) if the system provides for the resolu-  
8                   tion of claims through arbitration, the claims  
9                   brought under the system shall be heard and  
10                  resolved by arbitrators appointed by the Sec-  
11                  retary in consultation with the Attorney Gen-  
12                  eral; and

13                  (C) with respect to a State in which the  
14                  system is in effect, the Secretary may (at the  
15                  State's request) modify the system to take into  
16                  account the existence of dispute resolution pro-  
17                  cedures in the State that affect the resolution  
18                  of medical malpractice liability claims.

19           (3) TREATMENT OF STATES WITH ALTER-  
20           NATIVE SYSTEM IN EFFECT.—If the alternative Fed-  
21           eral ADR system established under this subsection is  
22           applied with respect to a State for a calendar year,  
23           the State shall make a payment to the United States  
24           (at such time and in such manner as the Secretary  
25           may require) in an amount equal to 110 percent of



1 the costs incurred by the United States during the  
2 year as a result of the application of the system with  
3 respect to the State.

4 **SEC. 6223. REPORTS ON IMPLEMENTATION AND EFFEC-**  
5 **TIVENESS OF ALTERNATIVE DISPUTE RESO-**  
6 **LUTION SYSTEMS.**

7 (a) IN GENERAL.—Not later than 5 years after the  
8 date of the enactment of this Act, the Secretary shall pre-  
9 pare and submit to the Congress a report describing and  
10 evaluating State alternative dispute resolution systems op-  
11 erated pursuant to this part and the alternative Federal  
12 system established under section 6222(b).

13 (b) CONTENTS OF REPORT.—The Secretary shall in-  
14 clude in the report prepared and submitted under sub-  
15 section (a)—

16 (1) information on—

17 (A) the effect of the alternative dispute  
18 resolution systems on the cost of health care  
19 within each State,

20 (B) the impact of such systems on the ac-  
21 cess of individuals to health care within the  
22 State, and

23 (C) the effect of such systems on the qual-  
24 ity of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

### **PART 3—DEFINITIONS**

#### **SEC. 6231. DEFINITIONS.**

As used in this subtitle:

(1) **ALTERNATIVE DISPUTE RESOLUTION SYSTEM.**—The term “alternative dispute resolution system” means a system that is enacted or adopted by a State to resolve medical malpractice claims other than through a medical malpractice liability action.

(2) **CLAIMANT.**—The term “claimant” means any person who brings a health care liability action and, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such an action is brought.

(3) **CLEAR AND CONVINCING EVIDENCE.**—The term “clear and convincing evidence” is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established,

1       except that such measure or degree of proof is more  
2       than that required under preponderance of the evi-  
3       dence, but less than that required for proof beyond  
4       a reasonable doubt.

5           (4) ECONOMIC DAMAGES.—The term “economic  
6       damages” means damages paid to compensate an in-  
7       dividual for losses for hospital and other medical ex-  
8       penses, lost wages, lost employment, and other pecu-  
9       niary losses.

10          (5) HEALTH CARE PROFESSIONAL.—The term  
11       “health care professional” means any individual who  
12       provides health care services in a State and who is  
13       required by State law or regulation to be licensed or  
14       certified by the State to provide such services in the  
15       State.

16          (6) HEALTH CARE PROVIDER.—The term  
17       “health care provider” means any organization or  
18       institution that is engaged in the delivery of health  
19       care services in a State that is required by State law  
20       or regulation to be licensed or certified by the State  
21       to engage in the delivery of such services in the  
22       State.

23          (7) INJURY.—The term “injury” means any ill-  
24       ness, disease, or other harm that is the subject of  
25       a medical malpractice claim.

1           (8) MEDICAL MALPRACTICE LIABILITY AC-  
2           TION.—The term “medical malpractice liability ac-  
3           tion” means any civil action brought pursuant to  
4           State law in which a plaintiff alleges a medical mal-  
5           practice claim against a health care provider or  
6           health care professional, but does not include any  
7           action in which the plaintiff’s sole allegation is an al-  
8           legation of an intentional tort.

9           (9) MEDICAL MALPRACTICE CLAIM.—The term  
10          “medical malpractice claim” means any claim relat-  
11          ing to the provision of (or the failure to provide)  
12          health care services or the use of a medical product,  
13          without regard to the theory of liability asserted,  
14          and includes any third-party claim, cross-claim,  
15          counterclaim, or contribution claim in a medical  
16          malpractice liability action.

17          (10) MEDICAL PRODUCT.—

18                (A) IN GENERAL.—The term “medical  
19                product” means, with respect to the allegation  
20                of a claimant, a drug (as defined in section  
21                201(g)(1) of the Federal Food, Drug, and Cos-  
22                metic Act (21 U.S.C. 321(g)(1)) or a medical  
23                device (as defined in section 201(h) of the Fed-  
24                eral Food, Drug, and Cosmetic Act (21 U.S.C.  
25                321(h)) if—

1 (i) such drug or device was subject to  
2 premarket approval under section 505,  
3 507, or 515 of the Federal Food, Drug,  
4 and Cosmetic Act (21 U.S.C. 355, 357, or  
5 360e) or section 351 of the Public Health  
6 Service Act (42 U.S.C. 262) with respect  
7 to the safety of the formulation or per-  
8 formance of the aspect of such drug or de-  
9 vice which is the subject of the claimant's  
10 allegation or the adequacy of the packag-  
11 ing or labeling of such drug or device, and  
12 such drug or device is approved by the  
13 Food and Drug Administration; or

14 (ii) the drug or device is generally rec-  
15 ognized as safe and effective under regula-  
16 tions issued by the Secretary of Health  
17 and Human Services under section 201(p)  
18 of the Federal Food, Drug, and Cosmetic  
19 Act (21 U.S.C. 321(p)).

20 (B) EXCEPTION IN CASE OF MISREPRE-  
21 SENTATION OR FRAUD.—Notwithstanding sub-  
22 paragraph (A), the term “medical product”  
23 shall not include any product described in such  
24 subparagraph if the claimant shows that the  
25 product is approved by the Food and Drug Ad-

1           ministration for marketing as a result of with-  
2           held information, misrepresentation, or an ille-  
3           gal payment by manufacturer of the product.

4           (11) NONECONOMIC DAMAGES.—The term  
5           “noneconomic damages” means damages paid to  
6           compensate an individual for losses for physical and  
7           emotional pain, suffering, inconvenience, physical  
8           impairment, mental anguish, disfigurement, loss of  
9           enjoyment of life, loss of consortium, and other  
10          nonpecuniary losses, but does not include punitive  
11          damages.

12          (12) PUNITIVE DAMAGES.—The term “punitive  
13          damages” means compensation, in addition to com-  
14          pensation for actual harm suffered, that is awarded  
15          for the purpose of punishing a person for conduct  
16          deemed to be malicious, wanton, willful, or exces-  
17          sively reckless.

## 18                   **Subtitle D—Administrative** 19                   **Simplification**

### 20   **SEC. 6300. PURPOSE.**

21          It is the purpose of this subtitle to improve the effi-  
22          ciency and effectiveness of the health care system, includ-  
23          ing the medicare program under title XVIII of the Social  
24          Security Act and the medicaid program under title XIX  
25          of such Act, by encouraging the development of a health

1 information network through the adoption of standards  
2 and the establishment of requirements for the electronic  
3 transmission of certain health information.

4 **SEC. 6301. DEFINITIONS.**

5 For purposes of this subtitle:

6 (1) CODE SET.—The term “code set” means  
7 any set of codes used for encoding data elements,  
8 such as tables of terms, medical concepts, medical  
9 diagnostic codes, or medical procedure codes.

10 (2) COORDINATION OF BENEFITS.—The term  
11 “coordination of benefits” means determining and  
12 coordinating the financial obligations of plan spon-  
13 sors when health care benefits are payable by more  
14 than one such sponsor.

15 (3) HEALTH INFORMATION.—The term “health  
16 information” means any information that relates to  
17 the past, present, or future physical or mental health  
18 or condition or functional status of an individual,  
19 the provision of health care to an individual, or pay-  
20 ment for the provision of health care to an individ-  
21 ual.

22 (4) HEALTH INFORMATION NETWORK.—The  
23 term “health information network” means the health  
24 information system that is formed through the appli-

1 cation of the requirements and standards established  
2 under this subtitle.

3 (5) HEALTH INFORMATION NETWORK SERV-  
4 ICE.—The term “health information network serv-  
5 ice”—

6 (A) means a private entity or an entity op-  
7 erated by a State that enters into contracts—

8 (i) to process or facilitate the process-  
9 ing of nonstandard data elements of health  
10 information into standard data elements;

11 (ii) to provide the means by which  
12 persons are connected to the health infor-  
13 mation network for purposes of meeting  
14 the requirements of this subtitle, including  
15 the holding of standard data elements of  
16 health information;

17 (iii) to provide authorized access to  
18 health information through the health in-  
19 formation network; or

20 (iv) to provide specific information  
21 processing services, such as automated co-  
22 ordination of benefits and claims trans-  
23 action routing; and

24 (B) includes a health information security  
25 organization.



1           (6) HEALTH INFORMATION SECURITY ORGANI-  
2           ZATION.—The term “health information security or-  
3           ganization” means a private entity or an entity oper-  
4           ated by a State that accesses standard data elements  
5           of health information through the health information  
6           network, processes such information into non-identi-  
7           fiable health information, and may store such infor-  
8           mation.

9           (7) HEALTH PROVIDER.—The term “health  
10          provider” includes a provider of services (as defined  
11          in section 1861(u) of the Social Security Act), a pro-  
12          vider of medical or other health services (as defined  
13          in section 1861(s) of such Act), and any other per-  
14          son (other than a plan sponsor) furnishing health  
15          care items or services.

16          (8) NON-IDENTIFIABLE HEALTH INFORMA-  
17          TION.—The term “non-identifiable health informa-  
18          tion” means health information that is not protected  
19          health information (as defined in subtitle E).

20          (9) PLAN SPONSOR.—The term “plan sponsor”  
21          means—

22                (A) a carrier (as defined in section  
23                1903(2)) providing health insurance coverage  
24                (as defined in section 1903(7));

25                (B) a group health plan;

1 (C) an association or other entity which es-  
2 tablishes or maintains a multiple employer wel-  
3 fare arrangement (as defined in section  
4 1903(12)) providing benefits consisting of medi-  
5 cal care described in section 607(1) of the Em-  
6 ployee Retirement Income Security Act of 1974;  
7 and

8 (D) a State, or the Federal Government,  
9 acting in a capacity as a provider of health ben-  
10 efits to eligible individuals that is equivalent to  
11 that of a carrier.

12 (10) STANDARD.—The term “standard”, when  
13 used with reference to a transaction or to data ele-  
14 ments of health information, means that the trans-  
15 action or data elements meet any standard adopted  
16 by the Secretary under part 1 that applies to the  
17 transaction or data elements.

18 **PART 1—STANDARDS FOR DATA ELEMENTS AND**  
19 **TRANSACTIONS**

20 **SEC. 6311. GENERAL REQUIREMENTS ON SECRETARY.**

21 (a) IN GENERAL.—The Secretary shall adopt stand-  
22 ards and modifications to standards under this part that  
23 are—

24 (1) consistent with the objective of reducing the  
25 costs of providing and paying for health care; and

1           (2) in use and generally accepted, developed, or  
2       modified by the standard-setting organizations ac-  
3       credited by the American National Standard Insti-  
4       tute.

5       (b) INITIAL STANDARDS.—The Secretary may de-  
6       velop an expedited process for the adoption of initial  
7       standards under this part.

8       (c) PROTECTION OF COMMERCIAL INFORMATION.—  
9       In adopting standards under this part, the Secretary may  
10      not require disclosure of trade secrets and confidential  
11      commercial information by any person.

12   **SEC. 6312. STANDARDS FOR DATA ELEMENTS OF HEALTH**  
13                           **INFORMATION.**

14      (a) IN GENERAL.—The Secretary shall adopt stand-  
15      ards necessary to make uniform and compatible for elec-  
16      tronic transmission through the health information net-  
17      work the data elements of any health information that the  
18      Secretary determines is appropriate for transmission in  
19      connection with a transaction described in section 6321.

20      (b) ADDITIONS.—The Secretary may make additions  
21      to any set of data elements adopted under subsection (a)  
22      as the Secretary determines appropriate in a manner that  
23      minimizes the disruption and cost of compliance with such  
24      additions.

25      (c) CERTAIN DATA ELEMENTS.—

1           (1) UNIQUE HEALTH IDENTIFIERS.—The Sec-  
2       retary shall establish a system to provide for a  
3       standard unique health identifier for each individual,  
4       employer, plan sponsor, and health provider for use  
5       in the health care system.

6           (2) CODE SETS.—

7           (A) IN GENERAL.—The Secretary, in con-  
8       sultation with experts from the private sector  
9       and Federal agencies, shall—

10               (i) select code sets for appropriate  
11               data elements from among the code sets  
12               that have been developed by private and  
13               public entities; or

14               (ii) establish code sets for such data  
15               elements if no code sets for the data ele-  
16               ments have been developed.

17           (B) DISTRIBUTION.—The Secretary shall  
18       establish efficient and low-cost procedures for  
19       distribution of code sets and modifications to  
20       code sets.

21   **SEC. 6313. INFORMATION TRANSACTION STANDARDS.**

22       (a) IN GENERAL.—The Secretary shall adopt tech-  
23       nical standards that are consistent with subtitle E relating  
24       to the method by which standard data elements of health  
25       information may be transmitted electronically, including

1 standards with respect to the format in which such data  
2 elements may be transmitted.

3       (b) SPECIAL RULE FOR COORDINATION OF BENE-  
4 FITS.—Any standard adopted by the Secretary under  
5 paragraph (1) that relates to coordination of benefits shall  
6 provide that a claim for reimbursement for health services  
7 furnished shall be tested, by an algorithm specified by the  
8 Secretary, against all records of enrollment and eligibility  
9 for the individual who received such services that are avail-  
10 able to the recipient of the claim through the health infor-  
11 mation network to determine any primary and secondary  
12 obligors for payment.

13       (c) ELECTRONIC SIGNATURE.—The Secretary, in co-  
14 ordination with the Secretary of Commerce, shall promul-  
15 gate regulations specifying procedures for the electronic  
16 transmission and authentication of signatures, compliance  
17 with which shall be deemed to satisfy State and Federal  
18 statutory requirements for written signatures with respect  
19 to transactions described in section 6321 and written sig-  
20 natures on health records and prescriptions.

21       (d) STANDARDS FOR CLAIMS FOR CLINICAL LABORA-  
22 TORY TESTS.—The standards under this section shall pro-  
23 vide that claims for clinical laboratory tests for which ben-  
24 efits are payable by a plan sponsor shall be submitted di-  
25 rectly by the person or entity that performed (or super-

1 vised the performance of) the tests to the sponsor in a  
2 manner consistent with (and subject to such exceptions  
3 as are provided under) the requirement for direct submis-  
4 sion of such claims under the medicare program.

5 **SEC. 6314. TIMETABLES FOR ADOPTION OF STANDARDS.**

6 (a) INITIAL STANDARDS FOR DATA ELEMENTS.—

7 The Secretary shall adopt standards relating to—

8 (1) the data elements for the information de-  
9 scribed in section 6312(a) not later than 9 months  
10 after the date of the enactment of this Act (except  
11 in the case of standards with respect to data ele-  
12 ments for claims attachments, which shall be adopt-  
13 ed not later than 24 months after the date of the  
14 enactment of this Act); and

15 (2) any addition to a set of data elements, in  
16 conjunction with making such an addition.

17 (b) INITIAL STANDARDS FOR INFORMATION TRANS-  
18 ACTIONS.—The Secretary shall adopt standards relating  
19 to information transactions under section 6313 not later  
20 than 9 months after the date of the enactment of this Act  
21 (except in the case of standards for claims attachments,  
22 which shall be adopted not later than 24 months after the  
23 date of the enactment of this Act).

24 (c) MODIFICATIONS TO STANDARDS.—

1           (1) IN GENERAL.—Except as provided in para-  
2       graph (2), the Secretary shall review the standards  
3       adopted under this part and shall adopt modified  
4       standards as determined appropriate, but not more  
5       frequently than once every 6 months. Any modifica-  
6       tion to standards shall be completed in a manner  
7       which minimizes the disruption to, and costs of com-  
8       pliance incurred by, a plan sponsor, health provider,  
9       or health plan purchasing organization that is re-  
10      quired to comply with part 2.

11           (2) SPECIAL RULES.—

12           (A) MODIFICATIONS DURING FIRST 12-  
13      MONTH PERIOD.—Except with respect to addi-  
14      tions and modifications to code sets under sub-  
15      paragraph (B), the Secretary may not adopt  
16      any modification to a standard adopted under  
17      this part during the 12-month period beginning  
18      on the date the standard is adopted, unless the  
19      Secretary determines that the modification is  
20      necessary in order to permit a plan sponsor, a  
21      health provider, or a health plan purchasing or-  
22      ganization to comply with part 2.

23           (B) ADDITIONS AND MODIFICATIONS TO  
24      CODE SETS.—

1 (i) IN GENERAL.—The Secretary shall  
2 ensure that procedures exist for the rou-  
3 tine maintenance, testing, enhancement,  
4 and expansion of code sets.

5 (ii) ADDITIONAL RULES.—If a code  
6 set is modified under this subsection, the  
7 modified code set shall include instructions  
8 on how data elements that were encoded  
9 prior to the modification are to be con-  
10 verted or translated so as to preserve the  
11 value of the data elements. Any modifica-  
12 tion to a code set under this subsection  
13 shall be implemented in a manner that  
14 minimizes the disruption to, and costs of  
15 compliance incurred by, a plan sponsor,  
16 health provider, or health plan purchasing  
17 organization that is required to comply  
18 with part 2.

19 (d) EVALUATION OF STANDARDS.—The Secretary  
20 may establish a process to measure or verify the consist-  
21 ency of standards adopted or modified under this part.  
22 Such process may include demonstration projects and  
23 analyses of the cost of implementing such standards and  
24 modifications.



1     **PART 2—REQUIREMENTS WITH RESPECT TO**  
2     **CERTAIN TRANSACTIONS AND INFORMATION**  
3     **SEC. 6321. STANDARD TRANSACTIONS AND INFORMATION.**

4         (a) TRANSACTIONS BY SPONSORS.—

5             (1) TRANSACTIONS WITH PROVIDERS.—If a  
6     plan sponsor conducts any of the transactions de-  
7     scribed in paragraph (3) with a health provider—

8                 (A) the transaction shall be a standard  
9     transaction; and

10                (B) the health information transmitted by  
11     the sponsor to the provider or by the provider  
12     to the sponsor in connection with the trans-  
13     action shall be in the form of standard data ele-  
14     ments.

15             (2) TRANSACTIONS WITH SPONSORS.—If a plan  
16     sponsor conducts any of the transactions described  
17     in paragraph (3) with another plan sponsor—

18                (A) the transaction shall be a standard  
19     transaction; and

20                (B) the health information transmitted by  
21     either sponsor in connection with the trans-  
22     action shall be in the form of standard data ele-  
23     ments.

24             (3) TRANSACTIONS.—The transactions referred  
25     to in paragraphs (1) and (2) are the following:

26                (A) Verification of eligibility for benefits.

1 (B) Coordination of benefits.

2 (C) Claim submission.

3 (D) Claim attachment submission.

4 (E) Claim status notification.

5 (F) Claim status verification.

6 (G) Claim adjudication.

7 (H) Payment and remittance advice.

8 (I) Certification or authorization of a re-  
9 ferral to a health provider who is not part of a  
10 provider network.

11 (b) TRANSACTIONS BY PURCHASING ORGANIZA-  
12 TIONS.—

13 (1) IN GENERAL.—If a health plan purchasing  
14 organization conducts any of the transactions de-  
15 scribed in paragraph (2) with a plan sponsor—

16 (A) the transaction shall be a standard  
17 transaction; and

18 (B) the health information transmitted by  
19 the organization to the sponsor or by the spon-  
20 sor to the organization in connection with the  
21 transaction shall be in the form of standard  
22 data elements.

23 (2) TRANSACTIONS.—The transactions referred  
24 to in paragraph (1) are the following:

25 (A) Enrollment and disenrollment.

1 (B) Premium payment.

2 (c) USE OF HEALTH INFORMATION NETWORK SERV-  
3 ICES.—A plan sponsor, a health provider, or a health plan  
4 purchasing organization may comply with any provision  
5 of this section by entering into an agreement or other ar-  
6 rangement with a health information network service cer-  
7 tified under section 6331 pursuant to which the service  
8 undertakes the duties applicable to the sponsor, provider,  
9 or organization under the provision.

10 **SEC. 6322. ACCESSING HEALTH INFORMATION FOR AU-**  
11 **THORIZED PURPOSES.**

12 (a) PROCUREMENT RULE FOR GOVERNMENT AGEN-  
13 CIES.—

14 (1) IN GENERAL.—A health information secu-  
15 rity organization that is certified under section 6331  
16 shall make available to a Federal or State agency,  
17 pursuant to a cost-type contract (as defined under  
18 the Federal Acquisition Regulation), any non-identi-  
19 fiable health information, including non-identifiable  
20 health information that is derived from protected  
21 health information, that—

22 (A) is held by the service or may be ob-  
23 tained by the service under paragraph (2) or  
24 subsection (b);

1 (B) consists of data elements that are sub-  
2 ject to a standard under part 1; and

3 (C) is requested by the agency to fulfill a  
4 requirement under this Act.

5 (2) CERTAIN INFORMATION AVAILABLE AT LOW  
6 COST.—If a health information security organization  
7 requires health information consisting of data ele-  
8 ments that are subject to a standard under part 1  
9 from a plan sponsor or a health provider in order to  
10 comply with a request made by a Federal or State  
11 agency under paragraph (1), the sponsor or provider  
12 shall make such information available to such orga-  
13 nization for a charge that does not exceed the rea-  
14 sonable cost of transmitting the information.

15 (b) PROCUREMENT RULE FOR INFORMATION SECU-  
16 RITY ORGANIZATIONS.—A health information security or-  
17 ganization that makes non-identifiable health information  
18 available to a Federal or State agency under subsection  
19 (a) shall make such non-identifiable information available,  
20 for a charge that does not exceed the reasonable cost of  
21 transmitting the information, to any other health informa-  
22 tion security organization that—

23 (A) is certified under section 6331; and

24 (B) requests the information.

1 **SEC. 6323. ENSURING AVAILABILITY OF INFORMATION.**

2 The Secretary shall establish a procedure under  
3 which a plan sponsor or health provider that does not have  
4 the ability to transmit standard data elements directly,  
5 and does not have access to a health information network  
6 service certified under section 6331, may comply with the  
7 provisions of this part.

8 **SEC. 6324. TIMETABLES FOR COMPLIANCE WITH REQUIRE-**  
9 **MENTS.**

10 (a) INITIAL COMPLIANCE.—

11 (1) IN GENERAL.—Not later than 12 months  
12 after the date on which standards are adopted under  
13 part 1 with respect to a type of transaction, or data  
14 elements for a type of health information, a plan  
15 sponsor, health provider, or health plan purchasing  
16 organization shall comply with the requirements of  
17 this part with respect to such transaction or infor-  
18 mation.

19 (2) ADDITIONAL DATA ELEMENTS.—Not later  
20 than 12 months after the date on which the Sec-  
21 retary adopts an addition to a set of data elements  
22 for health information under section 6312, a plan  
23 sponsor, health provider, or health plan purchasing  
24 organization shall comply with the requirements of  
25 this part using such data elements.

26 (b) COMPLIANCE WITH MODIFIED STANDARDS.—

1           (1) IN GENERAL.—If the Secretary adopts a  
2       modified standard under section 6314(c), a plan  
3       sponsor, health provider, or health plan purchasing  
4       organization shall comply with the modified standard  
5       at such time as the Secretary determines appro-  
6       priate, taking into account the time needed to com-  
7       ply due to the nature and extent of the modification.

8           (2) SPECIAL RULE.—In the case of a modifica-  
9       tion to a standard that does not occur within the 12-  
10      month period beginning on the date the standard is  
11      adopted, the time determined appropriate by the  
12      Secretary under paragraph (1) may not be—

13                (A) earlier than the last day of the 90-day  
14      period beginning on the date the modified  
15      standard is adopted; or

16                (B) later than the last day of the 12-  
17      month period beginning on the date the modi-  
18      fied standard is adopted.

### 19           **PART 3—MISCELLANEOUS PROVISIONS**

#### 20   **SEC. 6331. STANDARDS AND CERTIFICATION FOR HEALTH** 21           **INFORMATION NETWORK SERVICES.**

22           (a) STANDARDS FOR OPERATION.—The Secretary  
23      shall establish standards with respect to the operation of  
24      health information network services, including standards  
25      ensuring that such services—

1           (1) develop, operate, and cooperate with one an-  
2           other to form the health information network;

3           (2) meet all of the requirements under subtitle  
4           E that are applicable to the services;

5           (3) make public information concerning their  
6           performance, as measured by uniform indicators  
7           such as accessibility, transaction responsiveness, ad-  
8           ministrative efficiency, reliability, dependability, and  
9           any other indicator determined appropriate by the  
10          Secretary;

11          (4) have security procedures that are consistent  
12          with the requirements under subtitle E, including se-  
13          cure methods of accessing and transmitting data;  
14          and

15          (5) if they are part of a larger organization,  
16          have policies and procedures in place which isolate  
17          their activities with respect to processing informa-  
18          tion in a manner that prevents access to such infor-  
19          mation by such larger organization.

20          (b) CERTIFICATION BY THE SECRETARY.—

21               (1) ESTABLISHMENT.—Not later than 12  
22               months after the date of the enactment of this Act,  
23               the Secretary shall establish a certification proce-  
24               dure for health information network services which  
25               ensures that certified services are qualified to meet

1 the requirements of this subtitle and the standards  
2 established by the Secretary under this section. Such  
3 certification procedure shall be implemented in a  
4 manner that minimizes the costs and delays of oper-  
5 ations for such services.

6 (2) APPLICATION.—Each entity desiring to be  
7 certified as a health information network service  
8 shall apply to the Secretary for certification in a  
9 form and manner determined appropriate by the  
10 Secretary.

11 (3) AUDITS AND REPORTS.—The procedure es-  
12 tablished under paragraph (1) shall provide for au-  
13 dits by the Secretary and reports by an entity cer-  
14 tified under this section as the Secretary determines  
15 appropriate in order to monitor such entity's compli-  
16 ance with the requirements of this subtitle, subtitle  
17 E, and the standards established by the Secretary  
18 under this section.

19 (4) RECERTIFICATION.—A health information  
20 network service shall be recertified under this sub-  
21 section at least every 3 years.

22 (c) LOSS OF CERTIFICATION.—

23 (1) MANDATORY TERMINATION.—Except as  
24 provided in paragraph (2), if a health information  
25 network service violates a requirement imposed on



1       such service under subtitle E, its certification under  
2       this section shall be terminated unless the Secretary  
3       determines that appropriate corrective action has  
4       been taken.

5           (2) **CONDITIONAL CERTIFICATION**—The Sec-  
6       retary may establish a procedure under which a  
7       health information network service may remain cer-  
8       tified on a conditional basis if the service is operat-  
9       ing consistently with a plan intended to correct any  
10      violations described in paragraph (1). Such proce-  
11      dure may provide for the appointment of a trustee  
12      to continue operation of the service until the require-  
13      ments for full certification are met.

14      (d) **CERTIFICATION BY PRIVATE ENTITIES**.—The  
15      Secretary may designate private entities to conduct the  
16      certification procedures established by the Secretary under  
17      this section. A health information network service certified  
18      by such an entity in accordance with such designation  
19      shall be considered to be certified by the Secretary.

20      (e) **INFORMATION HELD BY HEALTH INFORMATION**  
21      **NETWORK SERVICES**.—If a health information network  
22      service certified under this section loses its certified status  
23      or takes any action that would threaten the continued  
24      availability of the standard data elements of health infor-  
25      mation held by such service, such data elements shall be

1 transferred to another health information network service  
2 certified under this section that has been designated by  
3 the Secretary.

4 **SEC. 6332. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

5 (a) IN GENERAL.—Except as provided in subsection  
6 (c), after the Secretary has established standards under  
7 section 6312 that are necessary to make uniform and com-  
8 patible for electronic transmission the data elements that  
9 the Secretary determines are appropriate for transmission  
10 in connection with a transaction described in part 2, an  
11 individual or entity may not require an individual or en-  
12 tity, to provide in any manner any additional data element  
13 in connection with—

- 14 (1) the transaction; or  
15 (2) an inquiry with respect to the transaction.

16 (b) TRANSMISSION METHOD.—Except as provided in  
17 subsection (c), after the Secretary has established stand-  
18 ards under section 6313 relating to the method by which  
19 data elements that the Secretary determines are appro-  
20 priate for transmission in connection with a transaction  
21 described in part 2 may be transmitted electronically, an  
22 individual or entity may not require an individual or entity  
23 to transmit any data element in a manner inconsistent  
24 with the standards in connection with—

- 25 (1) the transaction; or

1           (2) an inquiry with respect to the transaction.

2           (c) EXCEPTION.—Subsections (a) and (b) do not  
3 apply if—

4           (1) an individual or entity voluntarily agrees to  
5 provide the additional data element; or

6           (2) a waiver is granted under subsection (d) to  
7 permit the requirement to be imposed.

8           (d) CONDITIONS FOR WAIVERS.—

9           (1) IN GENERAL.—An individual or entity may  
10 request a waiver from the Secretary in order to im-  
11 pose on an individual or entity a requirement other-  
12 wise prohibited under subsection (a) or (b). Subject  
13 to paragraph (2), the Secretary may grant such a  
14 waiver.

15           (2) CONSIDERATION OF WAIVER REQUESTS.—A  
16 waiver may not be granted under this subsection to  
17 impose an otherwise prohibited requirement unless  
18 the Secretary determines that the value of any addi-  
19 tional information to be provided under the require-  
20 ment for research or other purposes significantly  
21 outweighs the administrative cost of the imposition  
22 of the requirement, taking into account the burden  
23 of the timing of the imposition of the requirement.

24           (e) ANONYMOUS REPORTING.—If an individual or en-  
25 tity attempts to impose on an individual or entity a re-

1   requirement prohibited under subsection (a) or (b), the indi-  
2   vidual or entity on whom the requirement is being imposed  
3   may contact the Secretary. The Secretary shall develop a  
4   procedure under which an individual or entity that con-  
5   tacts the Secretary under the preceding sentence shall re-  
6   main anonymous. The Secretary shall notify the individual  
7   or entity imposing the requirement that the requirement  
8   may not be imposed unless the other individual or entity  
9   voluntarily agrees to such requirement or a waiver is ob-  
10  tained under subsection (d).

11   **SEC. 6333. EFFECT ON STATE LAW.**

12       (a) IN GENERAL.—Except as otherwise provided in  
13   this section, a provision, requirement, or standard under  
14   this subtitle shall supersede any contrary provision of  
15   State law.

16       (b) STATE “QUILL AND PEN” LAWS.—A State may  
17   not establish, continue in effect, or enforce any provision  
18   of State law that requires medical or health plan records  
19   (including billing information) to be maintained or trans-  
20   mitted in written rather than electronic form, except  
21   where the Secretary determines that the provision is nec-  
22   essary to prevent fraud and abuse, with respect to con-  
23   trolled substances, or for other purposes.

24       (c) PUBLIC HEALTH REPORTING.—Nothing in this  
25   subtitle shall be construed to invalidate or limit the au-

1 thority, power, or procedures established under any law  
2 providing for the reporting of disease or injury, child  
3 abuse, birth, or death, public health surveillance, or public  
4 health investigation or intervention.

5 (d) PUBLIC USE FUNCTIONS.—Nothing in this sub-  
6 title shall be construed to limit the authority of a Federal  
7 or State agency to make non-identifiable health informa-  
8 tion available for public use.

9 (e) PAYMENT FOR HEALTH CARE SERVICES OR PRE-  
10 MIUMS.—Nothing in this subtitle shall be construed to  
11 prohibit a consumer from paying for health care items or  
12 services, or plan or health insurance coverage premiums,  
13 by debit, credit, or other payment cards or numbers or  
14 other electronic payment means.

15 **SEC. 6334. GRANTS FOR DEMONSTRATION PROJECTS.**

16 (a) IN GENERAL.—The Secretary may make grants  
17 for demonstration projects to promote the development  
18 and use of electronically integrated community-based clini-  
19 cal information systems and computerized patient medical  
20 records.

21 (b) APPLICATIONS.—

22 (1) SUBMISSION.—To apply for a grant under  
23 this section for any fiscal year, an applicant shall  
24 submit an application to the Secretary in accordance  
25 with the procedures established by the Secretary.

1           (2) CRITERIA FOR APPROVAL.—The Secretary  
2           may not approve an application submitted under  
3           paragraph (1) unless the application includes assur-  
4           ances satisfactory to the Secretary regarding the fol-  
5           lowing:

6                   (A) USE OF EXISTING TECHNOLOGY.—  
7           Funds received under this section will be used  
8           to apply telecommunications and information  
9           systems technology that is in existence on the  
10          date the application is submitted in a manner  
11          that improves the quality of health care, re-  
12          duces the costs of such care, and protects the  
13          privacy and confidentiality of information relat-  
14          ing to the physical or mental condition of an in-  
15          dividual.

16                  (B) USE OF EXISTING INFORMATION SYS-  
17          TEMS.—Funds received under this section will  
18          be used—

19                   (i) to enhance telecommunications or  
20                  information systems that are operating on  
21                  the date the application is submitted;

22                   (ii) to integrate telecommunications or  
23                  information systems that are operating on  
24                  the date the application is submitted; or

1                   (iii) to connect additional users to  
2                   telecommunications or information net-  
3                   works or systems that are operating on the  
4                   date the application is submitted.

5                   (C) CONSISTENCY WITH OTHER PROVI-  
6                   SIONS.—Funds received under this section will  
7                   be used for demonstration projects whose infor-  
8                   mation collection and disclosure requirements  
9                   are consistent with this subtitle and subtitle A  
10                  of title V.

11                  (D) MATCHING FUNDS.—The applicant  
12                  shall make available funds for the demonstra-  
13                  tion project in an amount that equals at least  
14                  20 percent of the cost of the project.

15                  (c) GEOGRAPHIC DIVERSITY.—In making any grants  
16                  under this section, the Secretary shall, to the extent prac-  
17                  ticable, make grants to persons representing different geo-  
18                  graphic areas of the United States, including urban and  
19                  rural areas.

20                  (d) REVIEW AND SANCTIONS.—The Secretary shall  
21                  review at least annually the compliance of a person receiv-  
22                  ing a grant under this section with the provisions of this  
23                  section. The Secretary shall establish a procedure for de-  
24                  termining whether such a person has failed to comply sub-

1   stantially within the provisions of this section and the  
2   sanctions to be imposed for any such noncompliance.

3       (e) ANNUAL REPORT.—The Secretary shall submit  
4   an annual report to the President for transmittal to Con-  
5   gress containing a description of the activities carried out  
6   under this section. The report shall evaluate each dem-  
7   onstration project that received funds under this section  
8   in the year to which the report pertains with respect to  
9   the following:

10           (1) The usefulness of the project in facilitating  
11       outcomes measurement, health provider decision-  
12       making, and health research.

13           (2) The cost and burden of the project on  
14       health providers and other participants in the  
15       project.

16           (3) Efficiency and effectiveness of the project in  
17       improving health care delivery and evaluation.

18       **PART 4—ASSISTANCE TO THE SECRETARY**

19       **SEC. 6341. GENERAL REQUIREMENT ON SECRETARY.**

20       In complying with any requirements imposed on the  
21   Secretary under this subtitle, the Secretary shall rely on  
22   recommendations of the Health Information Advisory  
23   Committee established under section 6342 and shall con-  
24   sult with appropriate Federal agencies.



1 **SEC. 6342. HEALTH INFORMATION ADVISORY COMMITTEE.**

2 (a) ESTABLISHMENT.—There is established a com-  
3 mittee to be known as the Health Care Information Advi-  
4 sory Committee.

5 (b) DUTY.—

6 (1) IN GENERAL.—The committee shall—

7 (A) provide assistance to the Secretary in  
8 complying with the requirements imposed on  
9 the Secretary under this subtitle and subtitle E;

10 (B) be generally responsible for advising  
11 the Secretary and the Congress on the status of  
12 the health information network; and

13 (C) make recommendations to correct any  
14 problems that may occur in the network's im-  
15 plementation and ongoing operations and to re-  
16 fine and improve the network.

17 (2) TECHNICAL ASSISTANCE.—In performing  
18 its duties under this subsection, the committee shall  
19 receive technical assistance from appropriate Federal  
20 agencies.

21 (c) MEMBERSHIP.—

22 (1) IN GENERAL.—The committee shall consist  
23 of 15 members to be appointed by the President not  
24 later than 60 days after the date of the enactment  
25 of this Act. The President shall designate 1 member  
26 as the Chair.

1           (2) EXPERTISE.—The membership of the com-  
2       mittee shall consist of individuals who are of recog-  
3       nized standing and distinction and who possess the  
4       demonstrated capacity to discharge the duties im-  
5       posed on the committee. At least 1 member of the  
6       committee shall be a member of the Health Quality  
7       Advisory Council established under section 4001.

8           (3) TERMS.—Each member of the committee  
9       shall be appointed for a term of 5 years, except that  
10      the members first appointed shall serve staggered  
11      terms such that the terms of no more than 3 mem-  
12      bers expire at one time.

13          (4) VACANCIES.—

14            (A) IN GENERAL.—A vacancy on the com-  
15       mittee shall be filled in the manner in which the  
16       original appointment was made and shall be  
17       subject to any conditions which applied with re-  
18       spect to the original appointment.

19            (B) FILLING UNEXPIRED TERM.—An indi-  
20       vidual chosen to fill a vacancy shall be ap-  
21       pointed for the unexpired term of the member  
22       replaced.

23            (C) EXPIRATION OF TERMS.—The term of  
24       any member shall not expire before the date on  
25       which the member's successor takes office.

1           (5) CONFLICTS OF INTEREST.—Members of the  
2       committee shall disclose upon appointment to the  
3       committee or at any subsequent time that it may  
4       occur, conflicts of interest.

5       (d) MEETINGS.—

6           (1) IN GENERAL.—Except as provided in para-  
7       graph (2), the committee shall meet at the call of  
8       the Chair.

9           (2) INITIAL MEETING.—Not later than 30 days  
10      after the date on which all members of the commit-  
11      tee have been appointed, the committee shall hold its  
12      first meeting.

13          (3) QUORUM.—A majority of the members of  
14      the committee shall constitute a quorum, but a less-  
15      er number of members may hold hearings.

16      (e) POWER TO HOLD HEARINGS.—The committee  
17      may hold such hearings, sit and act at such times and  
18      places, take such testimony, and receive such evidence as  
19      the committee considers advisable to carry out the pur-  
20      poses of this section.

21      (f) OTHER ADMINISTRATIVE PROVISIONS.—Subpara-  
22      graphs (C), (D), and (H) of section 1886(e)(6) of the So-  
23      cial Security Act shall apply to the committee in the same  
24      manner as they apply to the Prospective Payment Assess-  
25      ment Commission.

1 (g) REPORTS.—

2 (1) IN GENERAL.—The committee shall annu-  
3 ally prepare and submit to Congress and the Sec-  
4 retary a report including at least an analysis of—

5 (A) the status of the health information  
6 network established under this subtitle, includ-  
7 ing whether the network is fulfilling the pur-  
8 pose described in section 6300;

9 (B) the savings and costs of the network;

10 (C) the activities of health information net-  
11 work services certified under section 6331,  
12 health providers, and plan sponsors under this  
13 subtitle;

14 (D) the extent to which entities described  
15 in subparagraph (C) are meeting the standards  
16 adopted under this subtitle and working to-  
17 gether to form an integrated network that  
18 meets the needs of its users;

19 (E) the extent to which entities described  
20 in subparagraph (C) are meeting the privacy  
21 and security protections of subtitle E;

22 (F) whether the Federal Government and  
23 State Governments are receiving information of  
24 sufficient quality to meet their responsibilities  
25 under this Act;

1 (G) any problems with respect to imple-  
2 mentation of the network;

3 (H) the extent to which timetables under  
4 this subtitle for the adoption and implementa-  
5 tion of standards are being met; and

6 (I) any legislative recommendations related  
7 to the health information network.

8 (2) AVAILABILITY TO THE PUBLIC.—Any infor-  
9 mation in the report submitted to Congress under  
10 paragraph (1) shall be made available to the public,  
11 unless such information may not be disclosed by law.

12 (h) DURATION.—Notwithstanding section 14(a) of  
13 the Federal Advisory Committee Act, the committee shall  
14 continue in existence until otherwise provided by law.

15 **Subtitle E—Fair Health**  
16 **Information Practices**

17 **SEC. 6400. DEFINITIONS.**

18 (a) DEFINITIONS RELATING TO PROTECTED  
19 HEALTH INFORMATION.—For purposes of this subtitle:

20 (1) DISCLOSE.—The term “disclose”, when  
21 used with respect to protected health information  
22 that is held by a health information trustee, means  
23 to provide access to the information, but only if such  
24 access is provided by the trustee to a person other  
25 than—

1 (A) the trustee or an officer or employee of  
2 the trustee;

3 (B) an affiliated person of the trustee; or

4 (C) a protected individual who is a subject  
5 of the information.

6 (2) DISCLOSURE.—The term “disclosure”  
7 means the act or an instance of disclosing.

8 (3) PROTECTED HEALTH INFORMATION.—The  
9 term “protected health information” means any in-  
10 formation, whether oral or recorded in any form or  
11 medium—

12 (A) that is created or received in a State  
13 by—

14 (i) a health care provider;

15 (ii) a health benefit plan sponsor;

16 (iii) a health oversight agency;

17 (iv) a health information service orga-  
18 nization; or

19 (v) a public health authority;

20 (B) that relates in any way to the past,  
21 present, or future physical or mental health or  
22 condition or functional status of a protected in-  
23 dividual, the provision of health care to a pro-  
24 tected individual, or payment for the provision  
25 of health care to a protected individual; and

1 (C) that—

2 (i) identifies the individual; or

3 (ii) with respect to which there is a  
4 reasonable basis to believe that the infor-  
5 mation can be used to identify the individ-  
6 ual.

7 (4) PROTECTED INDIVIDUAL.—The term “pro-  
8 tected individual” means an individual who, with re-  
9 spect to a date—

10 (A) is living on the date; or

11 (B) has died within the 2-year period end-  
12 ing on the date.

13 (5) USE.—The term “use”, when used with re-  
14 spect to protected health information that is held by  
15 a health information trustee, means—

16 (A) to use, or provide access to, the infor-  
17 mation in any manner that does not constitute  
18 a disclosure; or

19 (B) any act or instance of using, or provid-  
20 ing access, described in subparagraph (A).

21 (b) DEFINITIONS RELATING TO HEALTH INFORMA-  
22 TION TRUSTEES.—For purposes of this subtitle:

23 (1) HEALTH BENEFIT PLAN.—The term  
24 “health benefit plan” means—

1           (A) any contract of health insurance, in-  
2           cluding any hospital or medical service policy or  
3           certificate, hospital or medical service plan con-  
4           tract, or health maintenance organization group  
5           contract, that is provided by a carrier; and

6           (B) an employee welfare benefit plan or  
7           other arrangement insofar as the plan or ar-  
8           rangement provides health benefits and is fund-  
9           ed in a manner other than through the pur-  
10          chase of one or more policies or contracts de-  
11          scribed in subparagraph (A).

12          (2) HEALTH BENEFIT PLAN SPONSOR.—The  
13          term “health benefit plan sponsor” means a person  
14          who, with respect to a specific item of protected  
15          health information, receives, creates, uses, main-  
16          tains, or discloses the information while acting in  
17          whole or in part in the capacity of—

18                (A) a carrier providing a health benefit  
19                plan;

20                (B) any other provider of a health benefit  
21                plan, including any public entity that provides  
22                payments for health care items and services  
23                under a health benefit plan that are equivalent  
24                to payments provided by a private person under  
25                such a plan; or



1 (C) an officer or employee of a person de-  
2 scribed in subparagraph (A) or (B).

3 (3) HEALTH CARE PROVIDER.—The term  
4 “health care provider” means a person who, with re-  
5 spect to a specific item of protected health informa-  
6 tion, receives, creates, uses, maintains, or discloses  
7 the information while acting in whole or in part in  
8 the capacity of—

9 (A) a person who is licensed, certified, reg-  
10 istered, or otherwise authorized by law to pro-  
11 vide an item or service that constitutes health  
12 care in the ordinary course of business or prac-  
13 tice of a profession;

14 (B) a Federal or State program that di-  
15 rectly provides items or services that constitute  
16 health care to beneficiaries; or

17 (C) an officer or employee of a person de-  
18 scribed in subparagraph (A) or (B).

19 (4) HEALTH INFORMATION SERVICE ORGANIZA-  
20 TION.—The term “health information service organi-  
21 zation” means a person who, with respect to a spe-  
22 cific item of protected health information, receives,  
23 creates, uses, maintains, or discloses the information  
24 while acting in whole or in part in the capacity of—

1 (A) a person, other than an affiliated per-  
2 son, who performs specific functions for which  
3 the Secretary has authorized (by means of a  
4 designation or certification) the person to re-  
5 ceive access to health care data in electronic or  
6 magnetic form that are regulated by this Act;  
7 or

8 (B) an officer or employee of a person de-  
9 scribed in subparagraph (A).

10 (5) HEALTH INFORMATION TRUSTEE.—The  
11 term “health information trustee” means—

12 (A) a health care provider;

13 (B) a health information service organiza-  
14 tion;

15 (C) a health oversight agency;

16 (D) a health benefit plan sponsor;

17 (E) a public health authority;

18 (F) a health researcher;

19 (G) a person who, with respect to a spe-  
20 cific item of protected health information, is not  
21 described in subparagraphs (A) through (F) but  
22 receives the information—

23 (i) pursuant to—

24 (I) section 6417 (relating to  
25 emergency circumstances);

1 (II) section 6418 (relating to ju-  
2 dicial and administrative purposes);

3 (III) section 6419 (relating to  
4 law enforcement); or

5 (IV) section 6420 (relating to  
6 subpoenas, warrants, and search war-  
7 rants); or

8 (ii) while acting in whole or in part in  
9 the capacity of an officer or employee of a  
10 person described in clause (i).

11 (6) HEALTH OVERSIGHT AGENCY.—The term  
12 “health oversight agency” means a person who, with  
13 respect to a specific item of protected health infor-  
14 mation, receives, creates, uses, maintains, or dis-  
15 closes the information while acting in whole or in  
16 part in the capacity of—

17 (A) a person who performs or oversees the  
18 performance of an assessment, evaluation, de-  
19 termination, or investigation relating to the li-  
20 censing, accreditation, or certification of health  
21 care providers;

22 (B) a person who—

23 (i) performs or oversees the perform-  
24 ance of an audit, assessment, evaluation,  
25 determination, or investigation relating to

1 the effectiveness of, compliance with, or  
2 applicability of, legal, fiscal, medical, or  
3 scientific standards or aspects of perform-  
4 ance related to the delivery of, or payment  
5 for, health care; and

6 (ii) is a public agency, acting on be-  
7 half of a public agency, acting pursuant to  
8 a requirement of a public agency, or carry-  
9 ing out activities under a State or Federal  
10 statute regulating the assessment, evalua-  
11 tion, determination, or investigation; or

12 (C) an officer or employee of a person de-  
13 scribed in subparagraph (A) or (B).

14 (7) HEALTH RESEARCHER.—The term “health  
15 researcher” means a person who, with respect to a  
16 specific item of protected health information, re-  
17 ceives the information—

18 (A) pursuant to section 6416 (relating to  
19 health research); or

20 (B) while acting in whole or in part in the  
21 capacity of an officer or employee of a person  
22 described in subparagraph (A).

23 (8) PUBLIC HEALTH AUTHORITY.—The term  
24 “public health authority” means a person who, with  
25 respect to a specific item of protected health infor-

1 mation, receives, creates, uses, maintains, or dis-  
2 closes the information while acting in whole or in  
3 part in the capacity of—

4 (A) an authority of the United States, a  
5 State, or a political subdivision of a State that  
6 is responsible for public health matters;

7 (B) a person acting under the direction of  
8 such an authority; or

9 (C) an officer or employee of a person de-  
10 scribed in subparagraph (A) or (B).

11 (c) OTHER DEFINITIONS.—For purposes of this sub-  
12 title:

13 (1) AFFILIATED PERSON.—The term “affiliated  
14 person” means a person who—

15 (A) is not a health information trustee;

16 (B) is a contractor, subcontractor, associ-  
17 ate, or subsidiary of a person who is a health  
18 information trustee; and

19 (C) pursuant to an agreement or other re-  
20 lationship with such trustee, receives, creates,  
21 uses, maintains, or discloses protected health  
22 information.

23 (2) APPROVED HEALTH RESEARCH PROJECT.—  
24 The term “approved health research project” means  
25 a biomedical, epidemiological, or health services re-

1 search or statistics project, or a research project on  
2 behavioral and social factors affecting health, that  
3 has been approved by a certified institutional review  
4 board.

5 (3) CERTIFIED INSTITUTIONAL REVIEW  
6 BOARD.—The term “certified institutional review  
7 board” means a board—

8 (A) established by an entity to review re-  
9 search involving protected health information  
10 and the rights of protected individuals con-  
11 ducted at or supported by the entity;

12 (B) established in accordance with regula-  
13 tions of the Secretary under section 6416(e)(1);  
14 and

15 (C) certified by the Secretary under section  
16 6416(e)(2).

17 (4) HEALTH CARE.—The term “health care”—

18 (A) means—

19 (i) any preventive, diagnostic, thera-  
20 peutic, rehabilitative, maintenance, or pal-  
21 liative care, counseling, service, or proce-  
22 dure—

23 (I) with respect to the physical or  
24 mental condition, or functional status,  
25 of an individual; or

1 (II) affecting the structure or  
2 function of the human body or any  
3 part of the human body, including  
4 banking of blood, sperm, organs, or  
5 any other tissue; or

6 (ii) any sale or dispensing of a drug,  
7 device, equipment, or other item to an indi-  
8 vidual, or for the use of an individual, pur-  
9 suant to a prescription; but

10 (B) does not include any item or service  
11 that is not furnished for the purpose of main-  
12 taining or improving the health of an individual.

13 (5) LAW ENFORCEMENT INQUIRY.—The term  
14 “law enforcement inquiry” means a lawful investiga-  
15 tion or official proceeding inquiring into a violation  
16 of, or failure to comply with, any criminal or civil  
17 statute or any regulation, rule, or order issued pur-  
18 suant to such a statute.

19 (6) PERSON.—The term “person” includes an  
20 authority of the United States, a State, or a political  
21 subdivision of a State.

1       **PART 1—DUTIES OF HEALTH INFORMATION**

2                               **TRUSTEES**

3       **SEC. 6401. INSPECTION OF PROTECTED HEALTH INFORMA-**  
4                               **TION.**

5           (a) IN GENERAL.—Except as provided in subsection  
6 (b), a health information trustee described in subsection  
7 (g)—

8                   (1) shall permit a protected individual to in-  
9                   spect any protected health information about the in-  
10                  dividual that the trustee maintains, any accounting  
11                  with respect to such information required under sec-  
12                  tion 6404, and any copy of an authorization re-  
13                  quired under section 6412 that pertains to such in-  
14                  formation;

15                  (2) shall provide the protected individual with a  
16                  copy of the information upon request by the individ-  
17                  ual and subject to any conditions imposed by the  
18                  trustee under subsection (d);

19                  (3) shall permit a person who has been des-  
20                  ignated in writing by the protected individual to in-  
21                  spect the information on behalf of the individual or  
22                  to accompany the individual during the inspection;  
23                  and

24                  (4) may offer to explain or interpret informa-  
25                  tion that is inspected or copied under this sub-  
26                  section.



1 (b) EXCEPTIONS.—A health information trustee is  
2 not required by this section to permit inspection or copy-  
3 ing of protected health information by a protected individ-  
4 ual if any of the following conditions apply:

5 (1) MENTAL HEALTH TREATMENT NOTES.—

6 The information consists of psychiatric, psycho-  
7 logical, or mental health treatment notes about the  
8 individual, the trustee determines in the exercise of  
9 reasonable professional judgment that inspection or  
10 copying of the notes would cause sufficient harm to  
11 the protected individual so as to outweigh the desir-  
12 ability of permitting access, and the trustee does not  
13 disclose the notes to any person not directly engaged  
14 in treating the individual, except with the authoriza-  
15 tion of the individual or under compulsion of law.

16 (2) INFORMATION ABOUT OTHERS.—The infor-  
17 mation relates to an individual, other than the pro-  
18 tected individual or a health care provider, and the  
19 trustee determines in the exercise of reasonable pro-  
20 fessional judgment that inspection or copying of the  
21 information would cause sufficient harm to one or  
22 both of the individuals so as to outweigh the desir-  
23 ability of permitting access.

24 (3) ENDANGERMENT TO LIFE OR SAFETY.—In-  
25 spection or copying of the information could reason-

1 ably be expected to endanger the life or physical  
2 safety of an individual.

3 (4) CONFIDENTIAL SOURCE.—The information  
4 identifies or could reasonably lead to the identifica-  
5 tion of an individual (other than a health care pro-  
6 vider) who provided information under a promise of  
7 confidentiality to a health care provider concerning  
8 a protected individual who is a subject of the infor-  
9 mation.

10 (5) ADMINISTRATIVE PURPOSES.—The informa-  
11 tion—

12 (A) is used by the trustee solely for admin-  
13 istrative purposes and not in the provision of  
14 health care to a protected individual who is a  
15 subject of the information; and

16 (B) is not disclosed by the trustee to any  
17 person.

18 (6) DUPLICATIVE INFORMATION.—The informa-  
19 tion duplicates information available for inspection  
20 under subsection (a).

21 (7) INFORMATION COMPILED IN ANTICIPATION  
22 OF LITIGATION.—The information is compiled prin-  
23 cipally—

24 (A) in anticipation of a civil, criminal, or  
25 administrative action or proceeding; or

1 (B) for use in such an action or proceed-  
2 ing.

3 (c) INSPECTION AND COPYING OF SEGREGABLE POR-  
4 TION.—A health information trustee shall permit inspec-  
5 tion and copying under subsection (a) of any reasonably  
6 segregable portion of a record after deletion of any portion  
7 that is exempt under subsection (b).

8 (d) CONDITIONS.—A health information trustee  
9 may—

10 (1) require a written request for the inspection  
11 and copying of protected health information under  
12 this section; and

13 (2) charge a reasonable cost-based fee for—

14 (A) permitting inspection of information  
15 under this section; and

16 (B) providing a copy of protected health  
17 information under this section.

18 (e) STATEMENT OF REASONS FOR DENIAL.—If a  
19 health information trustee denies in whole or in part a  
20 request for inspection or copying under this section, the  
21 trustee shall provide the protected individual who made  
22 the request with a written statement of the reasons for  
23 the denial.

24 (f) DEADLINE.—A health information trustee shall  
25 comply with or deny a request for inspection or copying

1 of protected health information under this section within  
2 the 30-day period beginning on the date the trustee re-  
3 ceives the request.

4 (g) APPLICABILITY.—This section applies to a health  
5 information trustee who is—

- 6 (1) a health benefit plan sponsor;
- 7 (2) a health care provider;
- 8 (3) a health information service organization;
- 9 (4) a health oversight agency; or
- 10 (5) a public health authority.

11 **SEC. 6402. AMENDMENT OF PROTECTED HEALTH INFORMA-**  
12 **TION.**

13 (a) IN GENERAL.—A health information trustee de-  
14 scribed in subsection (f) shall, within the 45-day period  
15 beginning on the date the trustee receives from a protected  
16 individual about whom the trustee maintains protected  
17 health information a written request that the trustee cor-  
18 rect or amend the information, complete the duties de-  
19 scribed in one of the following paragraphs:

20 (1) CORRECTION OR AMENDMENT AND NOTIFI-  
21 CATION.—The trustee shall—

22 (A) make the correction or amendment re-  
23 quested;

24 (B) inform the protected individual of the  
25 amendment or correction that has been made;

1           (C) make reasonable efforts to inform any  
2           person who is identified by the protected indi-  
3           vidual, who is not an employee of the trustee,  
4           and to whom the uncorrected or unamended  
5           portion of the information was previously dis-  
6           closed of the correction or amendment that has  
7           been made; and

8           (D) at the request of the individual, make  
9           reasonable efforts to inform any known source  
10          of the uncorrected or unamended portion of the  
11          information about the correction or amendment  
12          that has been made.

13          (2) REASONS FOR REFUSAL AND REVIEW PRO-  
14          CEDURES.—The trustee shall inform the protected  
15          individual of—

16                (A) the reasons for the refusal of the trust-  
17                ee to make the correction or amendment;

18                (B) any procedures for further review of  
19                the refusal; and

20                (C) the individual's right to file with the  
21                trustee a concise statement setting forth the re-  
22                quested correction or amendment and the indi-  
23                vidual's reasons for disagreeing with the refusal  
24                of the trustee.

1       (b) STANDARDS FOR CORRECTION OR AMEND-  
2 MENT.—A trustee shall correct or amend protected health  
3 information in accordance with a request made under sub-  
4 section (a) if the trustee determines that the information  
5 is not accurate, relevant, timely, or complete for the pur-  
6 poses for which the information may be used or disclosed  
7 by the trustee.

8       (c) STATEMENT OF DISAGREEMENT.—After a pro-  
9 tected individual has filed a statement of disagreement  
10 under subsection (a)(2)(C), the trustee, in any subsequent  
11 disclosure of the disputed portion of the information, shall  
12 include a copy of the individual's statement and may in-  
13 clude a concise statement of the trustee's reasons for not  
14 making the requested correction or amendment.

15       (d) CONSTRUCTION.—This section may not be con-  
16 strued to require a health information trustee to conduct  
17 a hearing or proceeding concerning a request for a correc-  
18 tion or amendment to protected health information the  
19 trustee maintains.

20       (e) CORRECTION.—For purposes of subsection (a), a  
21 correction is deemed to have been made to protected  
22 health information when—

23               (1) information that is not timely, accurate, rel-  
24 evant, or complete is clearly marked as incorrect; or

1           (2) supplementary correct information is made  
2       part of the information and adequately cross-ref-  
3       erenced.

4       (f) APPLICABILITY.—This section applies to a health  
5       information trustee who is—

- 6           (1) a health benefit plan sponsor;
- 7           (2) a health care provider;
- 8           (3) a health information service organization;
- 9           (4) a health oversight agency; or
- 10          (5) a public health authority.

11   **SEC. 6403. NOTICE OF INFORMATION PRACTICES.**

12       (a) PREPARATION OF NOTICE.—A health information  
13       trustee described in subsection (d) shall prepare a written  
14       notice of information practices describing the following:

15           (1) The rights under this subtitle of a protected  
16       individual who is the subject of protected health in-  
17       formation, including the right to inspect and copy  
18       such information and the right to seek amendments  
19       to such information, and the procedures for author-  
20       izing disclosures of protected health information and  
21       for revoking such authorizations.

22           (2) The procedures established by the trustee  
23       for the exercise of such rights.

24           (3) The uses and disclosures of protected health  
25       information that are authorized under this subtitle.

1 (b) DISSEMINATION OF NOTICE.—A health informa-  
2 tion trustee—

3 (1) shall, upon request, provide any person with  
4 a copy of the trustee's notice of information prac-  
5 tices (described in subsection (a)); and

6 (2) shall make reasonable efforts to inform per-  
7 sons in a clear and conspicuous manner of the exist-  
8 ence and availability of such notice.

9 (c) MODEL NOTICES.—Not later than July 1, 1996,  
10 the Secretary, after notice and opportunity for public com-  
11 ment, shall develop and disseminate model notices of infor-  
12 mation practices for use by health information trustees  
13 under this section.

14 (d) APPLICABILITY.—This section applies to a health  
15 information trustee who is—

16 (1) a health benefit plan sponsor;

17 (2) a health care provider;

18 (3) a health information service organization; or

19 (4) a health oversight agency.

20 **SEC. 6404. ACCOUNTING FOR DISCLOSURES.**

21 (a) IN GENERAL.—Except as provided in subsection  
22 (b) and section 6414, each health information trustee shall  
23 create and maintain, with respect to any protected health  
24 information the trustee discloses, a record of—

25 (1) the date and purpose of the disclosure;



1           (2) the name of the person to whom the disclo-  
2       sure was made;

3           (3) the address of the person to whom the dis-  
4       closure was made or the location to which the disclo-  
5       sure was made; and

6           (4) where practicable, a description of the infor-  
7       mation disclosed.

8       (b) REGULATIONS.—Not later than July 1, 1996, the  
9       Secretary shall promulgate regulations that exempt a  
10      health information trustee from maintaining a record  
11      under subsection (a) with respect protected health infor-  
12      mation disclosed by the trustee for purposes of peer re-  
13      view, licensing, certification, accreditation, and similar ac-  
14      tivities.

15   **SEC. 6405. SECURITY.**

16      (a) IN GENERAL.—Each health information trustee  
17      who receives or creates protected health information that  
18      is subject to this subtitle shall maintain reasonable and  
19      appropriate administrative, technical, and physical safe-  
20      guards—

21           (1) to ensure the integrity and confidentiality of  
22      the information;

23           (2) to protect against any reasonably antici-  
24      pated—

1           (A) threats or hazards to the security or  
2 integrity of the information; and

3           (B) unauthorized uses or disclosures of the  
4 information; and

5           (3) otherwise ensure compliance with this sub-  
6 title by the trustee and the officers and employees  
7 of the trustee.

8           (b) GUIDELINES.—Not later than July 1, 1996, the  
9 Secretary, after notice and opportunity for public com-  
10 ment, shall develop and disseminate guidelines for the im-  
11 plementation of this section. The guidelines shall take into  
12 account—

13           (1) the technical capabilities of record systems  
14 used to maintain protected health information;

15           (2) the costs of security measures;

16           (3) the need for training persons who have ac-  
17 cess to protected health information; and

18           (4) the value of audit trails in computerized  
19 record systems.

1   **PART 2—USE AND DISCLOSURE OF PROTECTED**  
2                   **HEALTH INFORMATION**

3   **SEC. 6411. GENERAL LIMITATIONS ON USE AND DISCLO-**  
4                   **SURE.**

5       (a) USE.—Except as otherwise provided under this  
6 subtitle, a health information trustee may use protected  
7 health information only for a purpose—

8           (1) that is compatible with and directly related  
9 to the purpose for which the information—

10               (A) was collected; or

11               (B) was received by the trustee; or

12           (2) for which the trustee is authorized to dis-  
13 close the information under this subtitle.

14       (b) DISCLOSURE.—A health information trustee may  
15 disclose protected health information only as authorized  
16 under this subtitle.

17       (c) SCOPE OF USES AND DISCLOSURES.—

18           (1) IN GENERAL.—A use or disclosure of pro-  
19 tected health information by a health information  
20 trustee shall be limited, when practicable, to the  
21 minimum amount of information necessary to ac-  
22 complish the purpose for which the information is  
23 used or disclosed.

24           (2) GUIDELINES.—Not later than July 1, 1996,  
25 the Secretary, after notice and opportunity for pub-  
26 lic comment, shall issue guidelines to implement

1 paragraph (1), which shall take into account the  
2 technical capabilities of the record systems used to  
3 maintain protected health information and the costs  
4 of limiting use and disclosure.

5 (d) IDENTIFICATION OF DISCLOSED INFORMATION  
6 AS PROTECTED INFORMATION.—Except with respect to  
7 protected health information that is disclosed under sec-  
8 tion 6414 (relating to next of kin and directory informa-  
9 tion), a health information trustee may disclose protected  
10 health information only if the recipient has been notified  
11 that the information is protected health information that  
12 is subject to this subtitle.

13 (e) AGREEMENT TO LIMIT USE OR DISCLOSURE.—  
14 A health information trustee who receives protected health  
15 information from any person pursuant to a written agree-  
16 ment to restrict use or disclosure of the information to  
17 a greater extent than otherwise would be required under  
18 this subtitle shall comply with the terms of the agreement,  
19 except where use or disclosure of the information in viola-  
20 tion of the agreement is required by law. A trustee who  
21 fails to comply with the preceding sentence shall be subject  
22 to section 6451 (relating to civil actions) with respect to  
23 such failure.

24 (f) NO GENERAL REQUIREMENT TO DISCLOSE.—  
25 Nothing in this subtitle shall be construed to require a

1 health information trustee to disclose protected health in-  
2 formation not otherwise required to be disclosed by law.

3 **SEC. 6412. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**  
4 **TECTED HEALTH INFORMATION.**

5 (a) WRITTEN AUTHORIZATIONS.—A health informa-  
6 tion trustee, other than a health information service orga-  
7 nization, may disclose protected health information pursu-  
8 ant to an authorization executed by the protected individ-  
9 ual who is the subject of the information, if each of the  
10 following requirements is satisfied:

11 (1) WRITING.—The authorization is in writing,  
12 signed by the individual, and dated on the date of  
13 such signature.

14 (2) SEPARATE FORM.—The authorization is not  
15 on a form used to authorize or facilitate the provi-  
16 sion of, or payment for, health care.

17 (3) TRUSTEE DESCRIBED.—The trustee is spe-  
18 cifically named or generically described in the au-  
19 thorization as authorized to disclose such informa-  
20 tion.

21 (4) RECIPIENT DESCRIBED.—The person to  
22 whom the information is to be disclosed is specifi-  
23 cally named or generically described in the author-  
24 ization as a person to whom such information may  
25 be disclosed.

1           (5) STATEMENT OF INTENDED USES AND DIS-  
2           CLOSURES RECEIVED.—The authorization contains  
3           an acknowledgment that the individual has received  
4           a statement described in subsection (b) from such  
5           person.

6           (6) INFORMATION DESCRIBED.—The informa-  
7           tion to be disclosed is described in the authorization.

8           (7) AUTHORIZATION TIMELY RECEIVED.—The  
9           authorization is received by the trustee during a pe-  
10          riod described in subsection (c)(1).

11          (8) DISCLOSURE TIMELY MADE.—The disclo-  
12          sure occurs during a period described in subsection  
13          (c)(2).

14          (b) STATEMENT OF INTENDED USES AND DISCLO-  
15          SURES.—

16               (1) IN GENERAL.—A person who wishes to re-  
17               ceive from a health information trustee protected  
18               health information about a protected individual pur-  
19               suant to an authorization executed by the individual  
20               shall supply the individual, in writing and on a form  
21               that is distinct from the authorization, with a state-  
22               ment of the uses for which the person intends the  
23               information and the disclosures the person intends  
24               to make of the information. Such statement shall be  
25               supplied before the authorization is executed.

1           (2) ENFORCEMENT.—If the person uses or dis-  
2 closes the information in a manner that is inconsis-  
3 tent with such statement, the person shall be subject  
4 to section 6451 (relating to civil actions) with re-  
5 spect to such failure, except where such use or dis-  
6 closure is required by law.

7           (3) MODEL STATEMENTS.—Not later than July  
8 1, 1996, the Secretary, after notice and opportunity  
9 for public comment, shall develop and disseminate  
10 model statements of intended uses and disclosures of  
11 the type described in paragraph (1).

12       (c) TIME LIMITATIONS ON AUTHORIZATIONS.—

13           (1) RECEIPT BY TRUSTEE.—For purposes of  
14 subsection (a)(7), an authorization is timely received  
15 if it is received by the trustee during—

16               (A) the 1-year period beginning on the  
17 date that the authorization is signed under sub-  
18 section (a)(1), if the authorization permits the  
19 disclosure of protected health information to—

- 20                       (i) a health benefit plan sponsor;  
21                       (ii) a health care provider;  
22                       (iii) a health oversight agency;  
23                       (iv) a public health authority;  
24                       (v) a health researcher; or

1 (vi) a person who provides counseling  
2 or social services to individuals; or

3 (B) the 30-day period beginning on the  
4 date that the authorization is signed under sub-  
5 section (a)(1), if the authorization permits the  
6 disclosure of protected health information to a  
7 person other than a person described in sub-  
8 paragraph (A).

9 (2) DISCLOSURE BY TRUSTEE.—For purposes  
10 of subsection (a)(8), a disclosure is timely made if  
11 it occurs before—

12 (A) the date or event (if any) specified in  
13 the authorization upon which the authorization  
14 expires; and

15 (B) the expiration of the 6-month period  
16 beginning on the date the trustee receives the  
17 authorization.

18 (d) REVOCATION OR AMENDMENT OF AUTHORIZA-  
19 TION.—

20 (1) IN GENERAL.—A protected individual in  
21 writing may revoke or amend an authorization de-  
22 scribed in subsection (a), in whole or in part, at any  
23 time, except insofar as—

24 (A) disclosure of protected health informa-  
25 tion has been authorized to permit validation of



1 expenditures based on health condition by a  
2 government authority; or

3 (B) action has been taken in reliance on  
4 the authorization.

5 (2) NOTICE OF REVOCATION.—A health infor-  
6 mation trustee who discloses protected health infor-  
7 mation in reliance on an authorization that has been  
8 revoked shall not be subject to any liability or pen-  
9 alty under this subtitle if—

10 (A) the reliance was in good faith;

11 (B) the trustee had no notice of the rev-  
12 ocation; and

13 (C) the disclosure was otherwise in accord-  
14 ance with the requirements of this section.

15 (e) ADDITIONAL REQUIREMENTS OF TRUSTEE.—A  
16 health information trustee may impose requirements for  
17 an authorization that are in addition to the requirements  
18 in this section.

19 (f) COPY.—A health information trustee who dis-  
20 closes protected health information pursuant to an author-  
21 ization under this section shall maintain a copy of the au-  
22 thorization.

23 (g) CONSTRUCTION.—This section may not be con-  
24 strued—

1           (1) to require a health information trustee to  
2       disclose protected health information; or

3           (2) to limit the right of a health information  
4       trustee to charge a fee for the disclosure or repro-  
5       duction of protected health information.

6       (h) SUBPOENAS, WARRANTS, AND SEARCH WAR-  
7       RANTS.—If a health information trustee discloses pro-  
8       tected health information pursuant to an authorization in  
9       order to comply with an administrative subpoena or war-  
10      rant or a judicial subpoena or search warrant, the author-  
11      ization—

12           (1) shall specifically authorize the disclosure for  
13      the purpose of permitting the trustee to comply with  
14      the subpoena, warrant, or search warrant; and

15           (2) shall otherwise meet the requirements in  
16      this section.

17   **SEC. 6413. TREATMENT, PAYMENT, AND OVERSIGHT.**

18       (a) DISCLOSURES BY PLANS, PROVIDERS, AND  
19      OVERSIGHT AGENCIES.—A health information trustee de-  
20      scribed in subsection (d) may disclose protected health in-  
21      formation to a health benefit plan sponsor, health care  
22      provider, or health oversight agency if the disclosure is—

23           (1) for the purpose of providing health care and  
24      a protected individual who is a subject of the infor-

1       mation has not previously objected to the disclosure  
2       in writing;

3           (2) for the purpose of providing for the pay-  
4       ment for health care furnished to an individual; or

5           (3) for use by a health oversight agency for a  
6       purpose that is described in subparagraph (A) or  
7       (B)(i) of section 6400(b)(6).

8       (b) DISCLOSURES BY CERTAIN OTHER TRUSTEES.—

9       A health information trustee may disclose protected health  
10      information to a health care provider if—

11           (1) the disclosure is for the purpose described  
12      in subsection (a)(1); and

13           (2) the trustee—

14                (A) is a public health authority;

15                (B) received protected health information  
16      pursuant to section 6417 (relating to emergency  
17      circumstances); or

18                (C) is an officer or employee of a trustee  
19      described in subsection (B).

20      (c) USE IN ACTION AGAINST INDIVIDUAL.—A person  
21      who receives protected health information about a pro-  
22      tected individual through a disclosure under this section  
23      may not use or disclose the information in any administra-  
24      tive, civil, or criminal action or investigation directed  
25      against the individual, except an action or investigation

1 arising out of and related to receipt of health care or pay-  
2 ment for health care.

3 (d) APPLICABILITY.—A health information trustee  
4 referred to in subsection (a) is any of the following:

5 (1) A health benefit plan sponsor.

6 (2) A health care provider.

7 (3) A health oversight agency.

8 (4) A health information service organization.

9 **SEC. 6414. NEXT OF KIN AND DIRECTORY INFORMATION.**

10 (a) NEXT OF KIN.—A health information trustee who  
11 is a health care provider, who received protected health  
12 information pursuant to section 6417 (relating to emer-  
13 gency circumstances), or who is an officer or employee of  
14 such a recipient may orally disclose protected health infor-  
15 mation about a protected individual to the next of kin of  
16 the individual (as defined under State law), or to a person  
17 with whom the individual has a close personal relationship,  
18 if—

19 (1) the trustee has no reason to believe that the  
20 individual would consider the information especially  
21 sensitive;

22 (2) the individual has not previously objected to  
23 the disclosure;

24 (3) the disclosure is consistent with good medi-  
25 cal or other professional practice; and

1           (4) the information disclosed is limited to infor-  
2           mation about health care that is being provided to  
3           the individual at or about the time of the disclosure.

4           (b) DIRECTORY INFORMATION.—

5           (1) IN GENERAL.—A health information trustee  
6           who is a health care provider, who received protected  
7           health information pursuant to section 6417 (relat-  
8           ing to emergency circumstances), or who is an offi-  
9           cer or employee of a such a recipient may disclose  
10          to any person the information described in para-  
11          graph (2) if—

12                   (A) a protected individual who is a subject  
13                   of the information has not objected in writing  
14                   to the disclosure;

15                   (B) the disclosure is otherwise consistent  
16                   with good medical and other professional prac-  
17                   tice; and

18                   (C) the information does not reveal specific  
19                   information about the physical or mental condi-  
20                   tion or functional status of a protected individ-  
21                   ual or about the health care provided to a pro-  
22                   tected individual.

23           (2) INFORMATION DESCRIBED.—The informa-  
24          tion referred to in paragraph (1) is the following:

1           (A) The name of an individual receiving  
2           health care from a health care provider on a  
3           premises controlled by the provider.

4           (B) The location of the individual on such  
5           premises.

6           (C) The general health status of the indi-  
7           vidual, described in terms of critical, poor, fair,  
8           stable, satisfactory, or terms denoting similar  
9           conditions.

10       (c) NO ACCOUNTING REQUIRED.—A health informa-  
11       tion trustee who discloses protected health information  
12       under this section is not required to maintain an account-  
13       ing of the disclosure under section 6404.

14       (d) RECIPIENTS.—A person to whom protected  
15       health information is disclosed under this section shall not,  
16       by reason of such disclosure, be subject to any require-  
17       ment under this subtitle.

18       **SEC. 6415. PUBLIC HEALTH.**

19       (a) IN GENERAL.—A health information trustee who  
20       is a health care provider or a public health authority may  
21       disclose protected health information to—

22           (1) a public health authority for use in legally  
23       authorized—

24           (A) disease or injury reporting;

25           (B) public health surveillance; or

1 (C) public health investigation or interven-  
2 tion; or

3 (2) an individual who is authorized by law to  
4 receive the information in a public health interven-  
5 tion.

6 (b) USE IN ACTION AGAINST INDIVIDUAL.—A public  
7 health authority who receives protected health information  
8 about a protected individual through a disclosure under  
9 this section may not use or disclose the information in any  
10 administrative, civil, or criminal action or investigation di-  
11 rected against the individual, except where the use or dis-  
12 closure is authorized by law for protection of the public  
13 health.

14 (c) INDIVIDUAL RECIPIENTS.—An individual to  
15 whom protected health information is disclosed under sub-  
16 section (a)(2) shall not, by reason of such disclosure, be  
17 subject to any requirement under this subtitle.

18 **SEC. 6416. HEALTH RESEARCH.**

19 (a) IN GENERAL.—A health information trustee de-  
20 scribed in subsection (d) may disclose protected health in-  
21 formation to a person if—

22 (1) the person is conducting an approved health  
23 research project;

24 (2) the information is to be used in the project;  
25 and

1           (3) the project has been determined by a cer-  
2       tified institutional review board to be—

3           (A) of sufficient importance so as to out-  
4       weigh the intrusion into the privacy of the pro-  
5       tected individual who is the subject of the infor-  
6       mation that would result from the disclosure;  
7       and

8           (B) impracticable to conduct without the  
9       information.

10       (b) DISCLOSURES BY HEALTH INFORMATION SERV-  
11       ICE ORGANIZATIONS.—A health information service orga-  
12       nization may disclose protected health information under  
13       subsection (a) only if the certified institutional review  
14       board referred to in subsection (a)(3) has been certified  
15       as being qualified to make determinations under such sub-  
16       section with respect to disclosures by such organizations.

17       (c) LIMITATIONS ON USE AND DISCLOSURE; OBLIGA-  
18       TIONS OF RECIPIENT.—A health researcher who receives  
19       protected health information about a protected individual  
20       pursuant to subsection (a)—

21           (1) may use the information solely for purposes  
22       of an approved health research project;

23           (2) may not use or disclose the information in  
24       any administrative, civil, or criminal action or inves-  
25       tigation directed against the individual; and



1           (3) shall remove or destroy, at the earliest op-  
2           portunity consistent with the purposes of the ap-  
3           proved health research project in connection with  
4           which the disclosure was made, information that  
5           would enable an individual to be identified, unless a  
6           certified institutional review board has determined  
7           that there is a health or research justification for re-  
8           tention of such identifiers and there is an adequate  
9           plan to protect the identifiers from use and disclo-  
10          sure that is inconsistent with this subtitle.

11          (d) APPLICABILITY.—A health information trustee  
12          referred to in subsection (a) is any health information  
13          trustee other than a person who, with respect to the spe-  
14          cific protected health information to be disclosed under  
15          such subsection, received the information—

16                (1) pursuant to—

17                    (A) section 6418 (relating to judicial and  
18                    administrative purposes);

19                    (B) paragraph (1), (2), or (3) of section  
20                    6419(a) (relating to law enforcement); or

21                    (C) section 6420 (relating to subpoenas,  
22                    warrants, and search warrants); or

23                (2) while acting in whole or in part in the ca-  
24                pacity of an officer or employee of a person de-  
25                scribed in paragraph (1).

1       (e) REQUIREMENTS FOR INSTITUTIONAL REVIEW  
2     BOARDS.—

3           (1) REGULATIONS.—Not later than July 1,  
4     1996, the Secretary, after opportunity for notice and  
5     comment, shall promulgate regulations establishing  
6     requirements for certified institutional review boards  
7     under this subtitle. The regulations shall be based  
8     on regulations promulgated under section 491(a) of  
9     the Public Health Service Act and shall ensure that  
10    certified institutional review boards are qualified to  
11    assess and protect the confidentiality of research  
12    subjects. The regulations shall include specific re-  
13    quirements for certified institutional review boards  
14    that make determinations under subsection (a)(3)  
15    with respect to disclosures by health information  
16    service organizations.

17          (2) CERTIFICATION.—The Secretary shall cer-  
18    tify that an institutional review board satisfies the  
19    requirements of the regulations promulgated under  
20    paragraph (1).

21   **SEC. 6417. EMERGENCY CIRCUMSTANCES.**

22          (a) IN GENERAL.—A health information trustee may  
23    disclose protected health information if the trustee be-  
24    lieves, on reasonable grounds, that the disclosure is nec-

1    essary to prevent or lessen a serious and imminent threat  
2    to the health or safety of an individual.

3           (b) **USE IN ACTION AGAINST INDIVIDUAL.**—A person  
4    who receives protected health information about a pro-  
5    tected individual through a disclosure under this section  
6    may not use or disclose the information in any administra-  
7    tive, civil, or criminal action or investigation directed  
8    against the individual, except an action or investigation  
9    arising out of and related to receipt of health care or pay-  
10   ment for health care.

11   **SEC. 6418. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

12           (a) **IN GENERAL.**—A health information trustee de-  
13   scribed in subsection (d) may disclose protected health in-  
14   formation—

15               (1) pursuant to the Federal Rules of Civil Pro-  
16   cedure, the Federal Rules of Criminal Procedure, or  
17   comparable rules of other courts or administrative  
18   agencies in connection with litigation or proceedings  
19   to which a protected individual who is a subject of  
20   the information is a party and in which the individ-  
21   ual has placed the individual's physical or mental  
22   condition or functional status in issue;

23               (2) if directed by a court in connection with a  
24   court-ordered examination of an individual; or

1           (3) to assist in the identification of a dead indi-  
2       vidual.

3       (b) WRITTEN STATEMENT.—A person seeking pro-  
4       tected health information about a protected individual held  
5       by health information trustee under—

6           (1) subsection (a)(1)—

7               (A) shall notify the protected individual or  
8               the attorney of the protected individual of the  
9               request for the information;

10              (B) shall provide the trustee with a signed  
11              document attesting—

12                   (i) that the protected individual is a  
13                   party to the litigation or proceedings for  
14                   which the information is sought;

15                   (ii) that the individual has placed the  
16                   individual's physical or mental condition or  
17                   functional status in issue; and

18                   (iii) the date on which the protected  
19                   individual or the attorney of the protected  
20                   individual was notified under subparagraph  
21                   (A); and

22               (C) shall not accept any requested pro-  
23               tected health information from the trustee until  
24               the termination of the 10-day period beginning

1           on the date notice was given under subpara-  
2           graph (A); or

3           (2) subsection (a)(3) shall provide the trustee  
4           with a written statement that the information is  
5           sought to assist in the identification of a dead indi-  
6           vidual.

7           (c) USE AND DISCLOSURE.—A person to whom pro-  
8           tected health information is disclosed under this section  
9           may use and disclose the information only to accomplish  
10          the purpose for which the disclosure was made.

11          (d) APPLICABILITY.—A health information trustee  
12          referred to in subsection (a) is any of the following:

13               (1) A health benefit plan sponsor.

14               (2) A health care provider.

15               (3) A health oversight agency.

16               (4) A person who, with respect to the specific  
17          protected health information to be disclosed under  
18          such subsection, received the information—

19                       (A) pursuant to—

20                               (i) section 6417 (relating to emer-  
21                               gency circumstances); or

22                               (ii) section 6420 (relating to subpoe-  
23                               nas, warrants, and search warrants); or

1 (B) while acting in whole or in part in the  
2 capacity of an officer or employee of a person  
3 described in subparagraph (A).

4 **SEC. 6419. LAW ENFORCEMENT.**

5 (a) IN GENERAL.—A health information trustee,  
6 other than a health information service organization, may  
7 disclose protected health information to a law enforcement  
8 agency, other than a health oversight agency—

9 (1) if the information is disclosed for use in an  
10 investigation or prosecution of a health information  
11 trustee;

12 (2) in connection with criminal activity commit-  
13 ted against the trustee or an affiliated person of the  
14 trustee or on premises controlled by the trustee; or

15 (3) if the information is needed to determine  
16 whether a crime has been committed and the nature  
17 of any crime that may have been committed (other  
18 than a crime that may have been committed by the  
19 protected individual who is the subject of the infor-  
20 mation).

21 (b) ADDITIONAL AUTHORITY OF CERTAIN TRUST-  
22 EES.—A health information trustee who is not a health  
23 information service organization, a public health author-  
24 ity, or a health researcher may disclose protected health

1 information to a law enforcement agency (other than a  
2 health oversight agency)—

3 (1) to assist in the identification or location of  
4 a victim, fugitive, or witness in a law enforcement  
5 inquiry;

6 (2) pursuant to a law requiring the reporting of  
7 specific health care information to law enforcement  
8 authorities; or

9 (3) if the information is specific health informa-  
10 tion described in paragraph (2) and the trustee is  
11 operated by a Federal agency;

12 (c) CERTIFICATION.—Where a law enforcement agen-  
13 cy requests a health information trustee to disclose pro-  
14 tected health information under subsection (a) or (b)(1),  
15 the agency shall provide the trustee with a written certifi-  
16 cation that—

17 (1) is signed by a supervisory official of a rank  
18 designated by the head of the agency;

19 (2) specifies the information requested; and

20 (3) states that the information is needed for a  
21 lawful purpose under this section.

22 (d) RESTRICTIONS ON DISCLOSURE AND USE.—A  
23 person who receives protected health information about a  
24 protected individual through a disclosure under this sec-  
25 tion may not use or disclose the information—

1           (1) in any administrative, civil, or criminal ac-  
2           tion or investigation directed against the individual,  
3           except an action or investigation arising out of and  
4           directly related to the action or investigation for  
5           which the information was obtained; and

6           (2) otherwise unless the use or disclosure is  
7           necessary to fulfill the purpose for which the infor-  
8           mation was obtained and is not prohibited by any  
9           other provision of law.

10 **SEC. 6420. SUBPOENAS, WARRANTS, AND SEARCH WAR-**  
11 **RANTS.**

12           (a) IN GENERAL.—A health information trustee de-  
13           scribed in subsection (g) may disclose protected health in-  
14           formation if the disclosure is pursuant to any of the fol-  
15           lowing:

16           (1) A subpoena issued under the authority of a  
17           grand jury and the trustee is provided a written cer-  
18           tification by the grand jury that the grand jury has  
19           complied with the applicable access provisions of sec-  
20           tion 6431.

21           (2) An administrative subpoena or warrant or  
22           a judicial subpoena or search warrant and the trust-  
23           ee is provided a written certification by the person  
24           seeking the information that the person has com-



1       plied with the applicable access provisions of section  
2       6431 or 6433(a).

3           (3) An administrative subpoena or warrant or  
4       a judicial subpoena or search warrant and the dis-  
5       closure otherwise meets the conditions of one of sec-  
6       tions 6413 through 6419.

7       (b) AUTHORITY OF ALL TRUSTEES.—Any health in-  
8       formation trustee may disclose protected health informa-  
9       tion if the disclosure is pursuant to subsection (a)(3).

10       (c) RESTRICTIONS ON USE AND DISCLOSURE.—Pro-  
11       tected health information about a protected individual that  
12       is disclosed by a health information trustee pursuant to—

13           (1) subsection (a)(2) may not be otherwise used  
14       or disclosed by the recipient unless the use or disclo-  
15       sure is necessary to fulfill the purpose for which the  
16       information was obtained; and

17           (2) subsection (a)(3) may not be used or dis-  
18       closed by the recipient unless the recipient complies  
19       with the conditions and restrictions on use and dis-  
20       closure with which the recipient would have been re-  
21       quired to comply if the disclosure by the trustee had  
22       been made under the section referred to in sub-  
23       section (a)(3) the conditions of which were met by  
24       the disclosure.

1 (d) RESTRICTIONS ON GRAND JURIES.—Protected  
2 health information that is disclosed by a health informa-  
3 tion trustee under subsection (a)(1)—

4 (1) shall be returnable on a date when the  
5 grand jury is in session and actually presented to  
6 the grand jury;

7 (2) shall be used only for the purpose of consid-  
8 ering whether to issue an indictment or report by  
9 that grand jury, or for the purpose of prosecuting a  
10 crime for which that indictment or report is issued,  
11 or for a purpose authorized by rule 6(e) of the Fed-  
12 eral Rules of Criminal Procedure or a comparable  
13 State rule;

14 (3) shall be destroyed or returned to the trustee  
15 if not used for one of the purposes specified in para-  
16 graph (2); and

17 (4) shall not be maintained, or a description of  
18 the contents of such information shall not be main-  
19 tained, by any government authority other than in  
20 the sealed records of the grand jury, unless such in-  
21 formation has been used in the prosecution of a  
22 crime for which the grand jury issued an indictment  
23 or presentment or for a purpose authorized by rule  
24 6(e) of the Federal Rules of Criminal Procedure or  
25 a comparable State rule.

1       (e) USE IN ACTION AGAINST INDIVIDUAL.—A person  
2 who receives protected health information about a pro-  
3 tected individual through a disclosure under this section  
4 may not use or disclose the information in any administra-  
5 tive, civil, or criminal action or investigation directed  
6 against the individual, except an action or investigation  
7 arising out of and directly related to the inquiry for which  
8 the information was obtained;

9       (f) CONSTRUCTION.—Nothing in this section shall be  
10 construed as authority for a health information trustee to  
11 refuse to comply with a valid administrative subpoena or  
12 warrant or a valid judicial subpoena or search warrant  
13 that meets the requirements of this subtitle.

14       (g) APPLICABILITY.—A health information trustee  
15 referred to in subsection (a) is any trustee other than the  
16 following:

17               (1) A health information service organization.

18               (2) A public health authority.

19               (3) A health researcher.

20 **SEC. 6421. HEALTH INFORMATION SERVICE ORGANIZA-**  
21 **TIONS.**

22       A health information trustee may disclose protected  
23 health information to a health information service organi-  
24 zation for the purpose of permitting the organization to  
25 perform a function for which the Secretary has authorized

1 (by means of a designation or certification) the organiza-  
2 tion to receive access to health care data in electronic or  
3 magnetic form that are regulated by this Act.

4 **PART 3—ACCESS PROCEDURES AND CHALLENGE**  
5 **RIGHTS**

6 **SEC. 6431. ACCESS PROCEDURES FOR LAW ENFORCEMENT**  
7 **SUBPOENAS, WARRANTS, AND SEARCH WAR-**  
8 **RANTS.**

9 (a) PROBABLE CAUSE REQUIREMENT.—A govern-  
10 ment authority may not obtain protected health informa-  
11 tion about a protected individual from a health informa-  
12 tion trustee under paragraph (1) or (2) of section 6420(a)  
13 for use in a law enforcement inquiry unless there is prob-  
14 able cause to believe that the information is relevant to  
15 a legitimate law enforcement inquiry being conducted by  
16 the government authority.

17 (b) WARRANTS AND SEARCH WARRANTS.—A govern-  
18 ment authority that obtains protected health information  
19 about a protected individual from a health information  
20 trustee under circumstances described in subsection (a)  
21 and pursuant to a warrant or search warrant shall, not  
22 later than 30 days after the date the warrant was served  
23 on the trustee, serve the individual with, or mail to the  
24 last known address of the individual, a copy of the  
25 warrant.

1 (c) SUBPOENAS.—Except as provided in subsection  
2 (d), a government authority may not obtain protected  
3 health information about a protected individual from a  
4 health information trustee under circumstances described  
5 in subsection (a) and pursuant to a subpoena unless a  
6 copy of the subpoena has been served by hand delivery  
7 upon the individual, or mailed to the last known address  
8 of the individual, on or before the date on which the sub-  
9 poena was served on the trustee, together with a notice  
10 (published by the Secretary under section 6435(1)) of the  
11 individual's right to challenge the subpoena in accordance  
12 with section 6432, and—

13 (1) 30 days have passed from the date of serv-  
14 ice, or 30 days have passed from the date of mailing,  
15 and within such time period the individual has not  
16 initiated a challenge in accordance with section  
17 6432; or

18 (2) disclosure is ordered by a court under sec-  
19 tion 6432.

20 (d) APPLICATION FOR DELAY.—

21 (1) IN GENERAL.—A government authority may  
22 apply to an appropriate court to delay (for an initial  
23 period of not longer than 90 days) serving a copy of  
24 a subpoena and a notice otherwise required under  
25 subsection (c) with respect to a law enforcement in-

1       quiry. The government authority may apply to the  
2       court for extensions of the delay.

3           (2) REASONS FOR DELAY.—An application for  
4       a delay, or extension of a delay, under this sub-  
5       section shall state, with reasonable specificity, the  
6       reasons why the delay or extension is being sought.

7           (3) EX PARTE ORDER.—The court shall enter  
8       an ex parte order delaying, or extending the delay  
9       of, the notice and an order prohibiting the trustee  
10      from revealing the request for, or the disclosure of,  
11      the protected health information being sought if the  
12      court finds that—

13           (A) the inquiry being conducted is within  
14      the lawful jurisdiction of the government  
15      authority seeking the protected health  
16      information;

17           (B) there is probable cause to believe that  
18      the protected health information being sought is  
19      relevant to a legitimate law enforcement inquiry  
20      being conducted by the government authority;

21           (C) the government authority's need for  
22      the information outweighs the privacy interest  
23      of the protected individual who is the subject of  
24      the information; and

1 (D) there are reasonable grounds to believe  
2 that receipt of a notice by the individual will re-  
3 sult in—

4 (i) endangering the life or physical  
5 safety of any individual;

6 (ii) flight from prosecution;

7 (iii) destruction of or tampering with  
8 evidence or the information being sought;

9 or

10 (iv) intimidation of potential wit-  
11 nesses.

12 (4) SERVICE OF APPLICATION ON INDIVID-  
13 UAL.—Upon the expiration of a period of delay of  
14 notice under this subsection, the government author-  
15 ity shall serve upon the individual, with the service  
16 of the subpoena and the notice, a copy of any appli-  
17 cations filed and approved under this subsection.

18 **SEC. 6432. CHALLENGE PROCEDURES FOR LAW ENFORCE-**  
19 **MENT SUBPOENAS.**

20 (a) MOTION TO QUASH SUBPOENA.—Within 30 days  
21 of the date of service, or 30 days of the date of mailing,  
22 of a subpoena of a government authority seeking protected  
23 health information about a protected individual from a  
24 health information trustee under paragraph (1) or (2) of  
25 section 6420(a) (except a subpoena to which section 6433

1 applies), the individual may file (without filing fee) a mo-  
2 tion to quash the subpoena—

3 (1) in the case of a State judicial subpoena, in  
4 the court which issued the subpoena;

5 (2) in the case of a subpoena issued under the  
6 authority of a State that is not a State judicial sub-  
7 poena, in a court of competent jurisdiction;

8 (3) in the case of a subpoena issued under the  
9 authority of a Federal court, in any court of the  
10 United States of competent jurisdiction; or

11 (4) in the case of any other subpoena issued  
12 under the authority of the United States, in—

13 (A) the United States district court for the  
14 district in which the individual resides or in  
15 which the subpoena was issued; or

16 (B) another United States district court of  
17 competent jurisdiction.

18 (b) COPY.—A copy of the motion shall be served by  
19 the individual upon the government authority by delivery  
20 of registered or certified mail.

21 (c) AFFIDAVITS AND SWORN DOCUMENTS.—The gov-  
22 ernment authority may file with the court such affidavits  
23 and other sworn documents as sustain the validity of the  
24 subpoena. The individual may file with the court, within  
25 5 days of the date of the authority's filing, affidavits and



1 sworn documents in response to the authority's filing. The  
2 court, upon the request of the individual, the government  
3 authority, or both, may proceed in camera.

4 (d) PROCEEDINGS AND DECISION ON MOTION.—The  
5 court may conduct such proceedings as it deems appro-  
6 priate to rule on the motion. All such proceedings shall  
7 be completed, and the motion ruled on, within 10 calendar  
8 days of the date of the government authority's filing.

9 (e) EXTENSION OF TIME LIMITS FOR GOOD  
10 CAUSE.—The court, for good cause shown, may at any  
11 time in its discretion enlarge the time limits established  
12 by subsections (c) and (d).

13 (f) STANDARD FOR DECISION.—A court may deny a  
14 motion under subsection (a) if it finds that there is prob-  
15 able cause to believe that the protected health information  
16 being sought is relevant to a legitimate law enforcement  
17 inquiry being conducted by the government authority, un-  
18 less the court finds that the individual's privacy interest  
19 outweighs the government authority's need for the infor-  
20 mation. The individual shall have the burden of dem-  
21 onstrating that the individual's privacy interest outweighs  
22 the need established by the government authority for the  
23 information.

24 (g) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
25 PRIVACY INTEREST.—In determining under subsection (f)

1 whether an individual's privacy interest outweighs the gov-  
2 ernment authority's need for the information, the court  
3 shall consider—

4 (1) the particular purpose for which the infor-  
5 mation was collected by the trustee;

6 (2) the degree to which disclosure of the infor-  
7 mation will embarrass, injure, or invade the privacy  
8 of the individual;

9 (3) the effect of the disclosure on the individ-  
10 ual's future health care;

11 (4) the importance of the inquiry being con-  
12 ducted by the government authority, and the impor-  
13 tance of the information to that inquiry; and

14 (5) any other factor deemed relevant by the  
15 court.

16 (h) ATTORNEY'S FEES.—In the case of any motion  
17 brought under subsection (a) in which the individual has  
18 substantially prevailed, the court, in its discretion, may as-  
19 sess against a government authority a reasonable attor-  
20 ney's fee and other litigation costs (including expert fees)  
21 reasonably incurred.

22 (i) NO INTERLOCUTORY APPEAL.—A court ruling de-  
23 nying a motion to quash under this section shall not be  
24 deemed a final order and no interlocutory appeal may be  
25 taken therefrom by the individual. An appeal of such a

1 ruling may be taken by the individual within such period  
2 of time as is provided by law as part of any appeal from  
3 a final order in any legal proceeding initiated against the  
4 individual arising out of or based upon the protect health  
5 information disclosed.

6 **SEC. 6433. ACCESS AND CHALLENGE PROCEDURES FOR**  
7 **OTHER SUBPOENAS.**

8 (a) IN GENERAL.—A person (other than a govern-  
9 ment authority seeking protected health information under  
10 circumstances described in section 6431(a)) may not ob-  
11 tain protected health information about a protected indi-  
12 vidual from a health information trustee pursuant to a  
13 subpoena under section 6420(a)(2) unless—

14 (1) a copy of the subpoena has been served  
15 upon the individual or mailed to the last known ad-  
16 dress of the individual on or before the date on  
17 which the subpoena was served on the trustee, to-  
18 gether with a notice (published by the Secretary  
19 under section 6435(2)) of the individual's right to  
20 challenge the subpoena, in accordance with sub-  
21 section (b); and

22 (2) either—

23 (A) 30 days have passed from the date of  
24 service or 30 days have passed from the date of  
25 the mailing and within such time period the in-

1           dividual has not initiated a challenge in accord-  
2           ance with subsection (b); or

3                   (B) disclosure is ordered by a court under  
4           such subsection.

5           (b) MOTION TO QUASH.—Within 30 days of the date  
6 of service or 30 days of the date of mailing of a subpoena  
7 seeking protected health information about a protected in-  
8 dividual from a health information trustee under sub-  
9 section (a), the individual may file (without filing fee) in  
10 any court of competent jurisdiction, a motion to quash the  
11 subpoena, with a copy served on the person seeking the  
12 information. The individual may oppose, or seek to limit,  
13 the subpoena on any grounds that would otherwise be  
14 available if the individual were in possession of the infor-  
15 mation.

16           (c) STANDARD FOR DECISION.—The court shall  
17 grant an individual's motion under subsection (b) if the  
18 person seeking the information has not sustained the bur-  
19 den of demonstrating that—

20                   (1) there are reasonable grounds to believe that  
21           the information will be relevant to a lawsuit or other  
22           judicial or administrative proceeding; and

23                   (2) the need of the person for the information  
24           outweighs the privacy interest of the individual.

1       (d) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
2 PRIVACY INTEREST.—In determining under subsection (c)  
3 whether the need of the person for the information out-  
4 weighs the privacy interest of the individual, the court  
5 shall consider—

6           (1) the particular purpose for which the infor-  
7 mation was collected by the trustee;

8           (2) the degree to which disclosure of the infor-  
9 mation will embarrass, injure, or invade the privacy  
10 of the individual;

11          (3) the effect of the disclosure on the individ-  
12 ual's future health care;

13          (4) the importance of the information to the  
14 lawsuit or proceeding; and

15          (5) any other factor deemed relevant by the  
16 court.

17       (e) ATTORNEY'S FEES.—In the case of any motion  
18 brought under subsection (b) by an individual against a  
19 person in which the individual has substantially prevailed,  
20 the court, in its discretion, may assess against the person  
21 a reasonable attorney's fee and other litigation costs (in-  
22 cluding expert fees) reasonably incurred.

1 **SEC. 6434. CONSTRUCTION OF PART; SUSPENSION OF STAT-**  
2 **UTE OF LIMITATIONS.**

3 (a) IN GENERAL.—Nothing in this part shall affect  
4 the right of a health information trustee to challenge a  
5 request for protected health information. Nothing in this  
6 part shall entitle a protected individual to assert the rights  
7 of a health information trustee.

8 (b) EFFECT OF MOTION ON STATUTE OF LIMITA-  
9 TIONS.—If an individual who is the subject of protected  
10 health information files a motion under this part which  
11 has the effect of delaying the access of a government au-  
12 thority to such information, the period beginning on the  
13 date such motion was filed and ending on the date on  
14 which the motion is decided shall be excluded in computing  
15 any period of limitations within which the government au-  
16 thority may commence any civil or criminal action in con-  
17 nection with which the access is sought.

18 **SEC. 6435. RESPONSIBILITIES OF SECRETARY.**

19 Not later than July 1, 1996, the Secretary, after no-  
20 tice and opportunity for public comment, shall develop and  
21 disseminate brief, clear, and easily understood model no-  
22 tices—

23 (1) for use under subsection (c) of section  
24 6431, detailing the rights of a protected individual  
25 who wishes to challenge, under section 6432, the dis-

1 closure of protected health information about the in-  
2 dividual under such subsection; and

3 (2) for use under subsection (a) of section  
4 6433, detailing the rights of a protected individual  
5 who wishes to challenge, under subsection (b) of  
6 such section, the disclosure of protected health infor-  
7 mation about the individual under such section.

8 **PART 4—MISCELLANEOUS PROVISIONS**

9 **SEC. 6441. PAYMENT CARD AND ELECTRONIC PAYMENT**  
10 **TRANSACTIONS.**

11 (a) PAYMENT FOR HEALTH CARE THROUGH CARD  
12 OR ELECTRONIC MEANS.—If a protected individual pays  
13 a health information trustee for health care by presenting  
14 a debit, credit, or other payment card or account number,  
15 or by any other electronic payment means, the trustee may  
16 disclose to a person described in subsection (b) only such  
17 protected health information about the individual as is  
18 necessary for the processing of the payment transaction  
19 or the billing or collection of amounts charged to, debited  
20 from, or otherwise paid by, the individual using the card,  
21 number, or other electronic payment means.

22 (b) TRANSACTION PROCESSING.—A person who is a  
23 debit, credit, or other payment card issuer, is otherwise  
24 directly involved in the processing of payment transactions  
25 involving such cards or other electronic payment trans-

1 actions, or is otherwise directly involved in the billing or  
2 collection of amounts paid through such means, may only  
3 use or disclose protected health information about a pro-  
4 tected individual that has been disclosed in accordance  
5 with subsection (a) when necessary for—

6 (1) the authorization, settlement, billing or col-  
7 lection of amounts charged to, debited from, or oth-  
8 erwise paid by, the individual using a debit, credit,  
9 or other payment card or account number, or by  
10 other electronic payment means;

11 (2) the transfer of receivables, accounts, or in-  
12 terest therein;

13 (3) the audit of the credit, debit, or other pay-  
14 ment card account information;

15 (4) compliance with Federal, State, or local law;  
16 or

17 (5) a properly authorized civil, criminal, or reg-  
18 ulatory investigation by Federal, State, or local au-  
19 thorities.

20 **SEC. 6442. ACCESS TO PROTECTED HEALTH INFORMATION**  
21 **OUTSIDE OF THE UNITED STATES.**

22 (a) IN GENERAL.—Notwithstanding the provisions of  
23 part 2, and except as provided in subsection (b), a health  
24 information trustee may not permit any person who is not  
25 in a State to have access to protected health information



1 about a protected individual unless one or more of the fol-  
2 lowing conditions exist:

3 (1) SPECIFIC AUTHORIZATION.—The individual  
4 has specifically consented to the provision of such  
5 access outside of the United States in an authoriza-  
6 tion that meets the requirements of section 6412.

7 (2) EQUIVALENT PROTECTION.—The provision  
8 of such access is authorized under this subtitle and  
9 the Secretary has determined that there are fair in-  
10 formation practices for protected health information  
11 in the jurisdiction where the access will be provided  
12 that provide protections for individuals and pro-  
13 tected health information that are equivalent to the  
14 protections provided for by this subtitle.

15 (3) ACCESS REQUIRED BY LAW.—The provision  
16 of such access is required under—

17 (A) a Federal statute; or

18 (B) a treaty or other international agree-  
19 ment applicable to the United States.

20 (b) EXCEPTIONS.—Subsection (a) does not apply  
21 where the provision of access to protected health informa-  
22 tion—

23 (1) is to a foreign public health authority;

24 (2) is authorized under section 6414 (relating  
25 to next of kin and directory information), 6416 (re-

1       lating to health research), or 6417 (relating to emer-  
2       gency circumstances); or

3           (3) is necessary for the purpose of providing for  
4       payment for health care that has been provided to  
5       an individual.

6   **SEC. 6443. STANDARDS FOR ELECTRONIC DOCUMENTS AND**  
7                   **COMMUNICATIONS.**

8       (a) STANDARDS.—Not later than July 1, 1996, the  
9       Secretary, after notice and opportunity for public com-  
10      ment and in consultation with appropriate private stand-  
11      ard-setting organizations and other interested parties,  
12      shall establish standards with respect to the creation,  
13      transmission, receipt, and maintenance, in electronic and  
14      magnetic form, of each type of written document specifi-  
15      cally required or authorized under this subtitle. Where a  
16      signature is required under any other provision of this  
17      part, such standards shall provide for an electronic or  
18      magnetic substitute that serves the functional equivalent  
19      of a signature.

20      (b) TREATMENT OF COMPLYING DOCUMENTS AND  
21      COMMUNICATIONS.—An electronic or magnetic document  
22      or communication that satisfies the standards established  
23      under subsection (a) with respect to such document or  
24      communication shall be treated as satisfying the require-

1 ments of this subtitle that apply to an equivalent written  
2 document.

3 **SEC. 6444. DUTIES AND AUTHORITIES OF AFFILIATED PER-**  
4 **SONS.**

5 (a) REQUIREMENTS ON TRUSTEES.—

6 (1) PROVISION OF INFORMATION.—A health in-  
7 formation trustee may provide protected health in-  
8 formation to a person who, with respect to the trust-  
9 ee, is an affiliated person and may permit the affili-  
10 ated person to use such information, only for the  
11 purpose of conducting, supporting, or facilitating an  
12 activity that the trustee is authorized to undertake.

13 (2) NOTICE TO AFFILIATED PERSON.—A health  
14 information trustee shall notify a person who, with  
15 respect to the trustee, is an affiliated person of any  
16 duties under this subtitle that the affiliated person  
17 is required to fulfill and of any authorities under  
18 this subtitle that the affiliated person is authorized  
19 to exercise.

20 (b) DUTIES OF AFFILIATED PERSONS.—

21 (1) IN GENERAL.—An affiliated person shall  
22 fulfill any duty under this subtitle that—

23 (A) the health information trustee with  
24 whom the person has an agreement or relation-

1 ship described in section 6400(c)(1)(C) is re-  
2 quired to fulfill; and

3 (B) the person has undertaken to fulfill  
4 pursuant to such agreement or relationship.

5 (2) CONSTRUCTION OF OTHER PARTS.—With  
6 respect to a duty described in paragraph (1) that an  
7 affiliated person is required to fulfill, the person  
8 shall be considered a health information trustee for  
9 purposes of this subtitle. The person shall be subject  
10 to part 5 (relating to enforcement) with respect to  
11 any such duty that the person fails to fulfill.

12 (3) EFFECT ON TRUSTEE.—An agreement or  
13 relationship with an affiliated person does not relieve  
14 a health information trustee of any duty or liability  
15 under this subtitle.

16 (c) AUTHORITIES OF AFFILIATED PERSONS.—

17 (1) IN GENERAL.—An affiliated person may  
18 only exercise an authority under this subtitle that  
19 the health information trustee with whom the person  
20 is affiliated may exercise and that the person has  
21 been given by the trustee pursuant to an agreement  
22 or relationship described in section 6400(c)(1)(C).  
23 With respect to any such authority, the person shall  
24 be considered a health information trustee for pur-  
25 poses of this subtitle. The person shall be subject to

1 part 5 (relating to enforcement) with respect to any  
2 act that exceeds such authority.

3 (2) EFFECT ON TRUSTEE.—An agreement or  
4 relationship with an affiliated person does not affect  
5 the authority of a health information trustee under  
6 this subtitle.

7 **SEC. 6445. AGENTS AND ATTORNEYS.**

8 (a) IN GENERAL.—Except as provided in subsections  
9 (b) and (c), a person who is authorized by law (on grounds  
10 other than an individual's minority), or by an instrument  
11 recognized under law, to act as an agent, attorney, proxy,  
12 or other legal representative for a protected individual or  
13 the estate of a protected individual, or otherwise to exer-  
14 cise the rights of the individual or estate, may, to the ex-  
15 tent authorized, exercise and discharge the rights of the  
16 individual or estate under this subtitle.

17 (b) HEALTH CARE POWER OF ATTORNEY.—A person  
18 who is authorized by law (on grounds other than an indi-  
19 vidual's minority), or by an instrument recognized under  
20 law, to make decisions about the provision of health care  
21 to an individual who is incapacitated may exercise and dis-  
22 charge the rights of the individual under this subtitle to  
23 the extent necessary to effectuate the terms or purposes  
24 of the grant of authority.

1 (c) NO COURT DECLARATION.—If a health care pro-  
2 vider determines that an individual, who has not been de-  
3 clared to be legally incompetent, suffers from a medical  
4 condition that prevents the individual from acting know-  
5 ingly or effectively on the individual's own behalf, the right  
6 of the individual to authorize disclosure under section  
7 6412 may be exercised and discharged in the best interest  
8 of the individual by—

9 (1) a person described in subsection (b) with re-  
10 spect to the individual;

11 (2) a person described in subsection (a) with re-  
12 spect to the individual, but only if a person de-  
13 scribed in paragraph (1) cannot be contacted after  
14 a reasonable effort;

15 (3) the next of kin of the individual, but only  
16 if a person described in paragraph (1) or (2) cannot  
17 be contacted after a reasonable effort; or

18 (4) the health care provider, but only if a per-  
19 son described in paragraph (1), (2), or (3) cannot be  
20 contacted after a reasonable effort.

21 **SEC. 6446. MINORS.**

22 (a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-  
23 BLE.—In the case of an individual—

1           (1) who is 18 years of age or older, all rights  
2           of the individual shall be exercised by the individual,  
3           except as provided in section 6445; or

4           (2) who, acting alone, has the legal capacity to  
5           apply for and obtain health care and has sought  
6           such care, the individual shall exercise all rights of  
7           an individual under this subtitle with respect to pro-  
8           tected health information relating to such care.

9           (b) INDIVIDUALS UNDER 18.—Except as provided in  
10          subsection (a)(2), in the case of an individual who is—

11           (1) under 14 years of age, all the individual's  
12           rights under this subtitle shall be exercised through  
13           the parent or legal guardian of the individual; or

14           (2) 14, 15, 16, or 17 years of age, the right of  
15           inspection (under section 6401), the right of amend-  
16           ment (under section 6402), and the right to author-  
17           ize disclosure of protected health information (under  
18           section 6412) of the individual may be exercised ei-  
19           ther by the individual or by the parent or legal  
20           guardian of the individual.

21   **SEC. 6447. MAINTENANCE OF CERTAIN PROTECTED**  
22                           **HEALTH INFORMATION.**

23           (a) IN GENERAL.—A State shall establish a process  
24           under which the protected health information described in  
25           subsection (b) that is maintained by a person described

1 in subsection (c) is delivered to, and maintained by, the  
2 State or an individual or entity designated by the State.

3 (b) INFORMATION DESCRIBED.—The protected  
4 health information referred to in subsection (a) is pro-  
5 tected health information that—

6 (1) is recorded in any form or medium;

7 (2) is created by—

8 (A) a health care provider; or

9 (B) a health benefit plan sponsor that pro-  
10 vides benefits in the form of items and services  
11 to enrollees and not in the form of reimburse-  
12 ment for items and services; and

13 (3) relates in any way to the past, present, or  
14 future physical or mental health or condition or  
15 functional status of a protected individual or the  
16 provision of health care to a protected individual.

17 (c) PERSONS DESCRIBED.—A person referred to in  
18 subsection (a) is any of the following:

19 (1) A health care facility previously located in  
20 the State that has closed.

21 (2) A professional practice previously operated  
22 by a health care provider in the State that has  
23 closed.

24 (3) A health benefit plan sponsor that—



1 (A) previously provided benefits in the  
2 form of items and services to enrollees in the  
3 State; and

4 (B) has ceased to do business.

5 **PART 5—ENFORCEMENT**

6 **SEC. 6451. CIVIL ACTIONS.**

7 (a) IN GENERAL.—Any individual whose right under  
8 this subtitle has been knowingly or negligently violated—

9 (1) by a health information trustee, or any  
10 other person, who is not described in paragraph (2),  
11 (3), (4), or (5) may maintain a civil action for actual  
12 damages and for equitable relief against the health  
13 information trustee or other person;

14 (2) by an officer or employee of the United  
15 States while the officer or employee was acting with-  
16 in the scope of the office or employment may main-  
17 tain a civil action for actual damages and for equi-  
18 table relief against the United States;

19 (3) by an officer or employee of any government  
20 authority of a State that has waived its sovereign  
21 immunity to a claim for damages resulting from a  
22 violation of this subtitle while the officer or employee  
23 was acting within the scope of the office or employ-  
24 ment may maintain a civil action for actual damages

1       and for equitable relief against the State govern-  
2       ment;

3           (4) by an officer or employee of a government  
4       of a State that is not described in paragraph (3)  
5       may maintain a civil action for actual damages and  
6       for equitable relief against the officer or employee;  
7       or

8           (5) by an officer or employee of a government  
9       authority while the officer or employee was not act-  
10      ing within the scope of the office or employment  
11      may maintain a civil action for actual damages and  
12      for equitable relief against the officer or employee.

13      (b) KNOWING VIOLATIONS.—Any individual entitled  
14      to recover actual damages under this section because of  
15      a knowing violation of a provision of this subtitle (other  
16      than subsection (c) or (d) of section 6411) shall be entitled  
17      to recover the amount of the actual damages demonstrated  
18      or \$5,000, whichever is greater.

19      (c) ACTUAL DAMAGES.—For purposes of this section,  
20      the term “actual damages” includes damages paid to com-  
21      pensate an individual for nonpecuniary losses such as  
22      physical and mental injury as well as damages paid to  
23      compensate for pecuniary losses.

24      (d) PUNITIVE DAMAGES; ATTORNEY’S FEES.—In  
25      any action brought under this section in which the com-

1 plaintiff has prevailed because of a knowing violation of  
2 a provision of this subtitle (other than subsection (c) or  
3 (d) of section 6411), the court may, in addition to any  
4 relief awarded under subsections (a) and (b), award such  
5 punitive damages as may be warranted. In such an action,  
6 the court, in its discretion, may allow the prevailing party  
7 a reasonable attorney's fee (including expert fees) as part  
8 of the costs, and the United States shall be liable for costs  
9 the same as a private person.

10 (e) LIMITATION.—A civil action under this section  
11 may not be commenced more than 2 years after the date  
12 on which the aggrieved individual discovered the violation  
13 or the date on which the aggrieved individual had a rea-  
14 sonable opportunity to discover the violation, whichever oc-  
15 curs first.

16 (f) INSPECTION AND AMENDMENT.—If a health in-  
17 formation trustee has established a formal internal proce-  
18 dure that allows an individual who has been denied inspec-  
19 tion or amendment of protected health information to ap-  
20 peal the denial, the individual may not maintain a civil  
21 action in connection with the denial until the earlier of—

22 (1) the date the appeal procedure has been ex-  
23 hausted; or

24 (2) the date that is 4 months after the date on  
25 which the appeal procedure was initiated.

1 (g) NO LIABILITY FOR PERMISSIBLE DISCLO-  
2 SURES.—A health information trustee who makes a disclo-  
3 sure of protected health information about a protected in-  
4 dividual that is permitted by this subtitle and not other-  
5 wise prohibited by State or Federal statute shall not be  
6 liable to the individual for the disclosure under common  
7 law.

8 (h) NO LIABILITY FOR INSTITUTIONAL REVIEW  
9 BOARD DETERMINATIONS.—If the members of a certified  
10 institutional review board have in good faith determined  
11 that an approved health research project is of sufficient  
12 importance so as to outweigh the intrusion into the privacy  
13 of an individual pursuant to section 6416(a)(1), the mem-  
14 bers, the board, and the parent institution of the board  
15 shall not be liable to the individual as a result of such  
16 determination.

17 (i) GOOD FAITH RELIANCE ON CERTIFICATION.—A  
18 health information trustee who relies in good faith on a  
19 certification by a government authority or other person  
20 and discloses protected health information about an indi-  
21 vidual in accordance with this subtitle shall not be liable  
22 to the individual for such disclosure.

23 **SEC. 6452. CIVIL MONEY PENALTIES.**

24 (a) VIOLATION.—Any health information trustee who  
25 the Secretary determines has demonstrated a pattern or

1 practice of failure to comply with the provisions of this  
2 subtitle shall be subject, in addition to any other penalties  
3 that may be prescribed by law, to a civil money penalty  
4 of not more than \$10,000 for each such failure. In deter-  
5 mining the amount of any penalty to be assessed under  
6 the procedures established under subsection (b), the Sec-  
7 retary shall take into account the previous record of com-  
8 pliance of the person being assessed with the applicable  
9 requirements of this subtitle and the gravity of the  
10 violation.

11 (b) PROCEDURES FOR IMPOSITION OF PENALTIES.—  
12 The provisions of section 1128A of the Social Security Act  
13 (other than subsections (a) and (b)) shall apply to the im-  
14 position of a civil monetary penalty under this section in  
15 the same manner as such provisions apply with respect  
16 to the imposition of a penalty under section 1128A of such  
17 Act.

18 **SEC. 6453. ALTERNATIVE DISPUTE RESOLUTION.**

19 (a) IN GENERAL.—Not later than July 1, 1996, the  
20 Secretary shall, by regulation, develop alternative dispute  
21 resolution methods for use by individuals, health informa-  
22 tion trustees, and other persons in resolving claims under  
23 section 6451.

24 (b) EFFECT ON INITIATION OF CIVIL ACTIONS.—

1           (1) IN GENERAL.—Subject to paragraph (2),  
2           the regulations established under subsection (a) may  
3           provide that an individual alleging that a right of  
4           the individual under this subtitle has been violated  
5           shall pursue at least one alternative dispute resolu-  
6           tion method developed under such subsection as a  
7           condition precedent to commencing a civil action  
8           under section 6451.

9           (2) LIMITATION.—Such regulations may not re-  
10          quire an individual to refrain from commencing a  
11          civil action to pursue one or more alternative dispute  
12          resolution method for a period that is greater than  
13          6 months.

14          (3) SUSPENSION OF STATUTE OF LIMITA-  
15          TIONS.—The regulations established by the Sec-  
16          retary under subsection (a) may provide that a pe-  
17          riod in which an individual described in paragraph  
18          (1) pursues (as defined by the Secretary) an alter-  
19          native dispute resolution method under this section  
20          shall be excluded in computing the period of limita-  
21          tions under section 6451(e).

22          (c) METHODS.—The methods under subsection (a)  
23          shall include at least the following:

24                  (1) ARBITRATION.—The use of arbitration.

25                  (2) MEDIATION.—The use of mediation.

1           (3) EARLY OFFERS OF SETTLEMENT.—The use  
 2           of a process under which parties make early offers  
 3           of settlement.

4           (d) STANDARDS FOR ESTABLISHING METHODS.—In  
 5           developing alternative dispute resolution methods under  
 6           subsection (a), the Secretary shall ensure that the meth-  
 7           ods promote the resolution of claims in a manner that—

8                   (1) is affordable for the parties involved;

9                   (2) provides for timely and fair resolution of  
 10          claims; and

11                  (3) provides for reasonably convenient access to  
 12          dispute resolution for individuals.

13   **SEC. 6454. AMENDMENTS TO CRIMINAL LAW.**

14          (a) IN GENERAL.—Title 18, United States Code, is  
 15          amended by inserting after chapter 89 the following:

16                   **“CHAPTER 90—PROTECTED HEALTH**  
 17                   **INFORMATION**

“Sec.

“1831. Definitions.

“1832. Obtaining protected health information under false pretenses.

“1833. Monetary gain from obtaining protected health information under false  
 pretenses.

“1834. Knowing and unlawful obtaining of protected health information.

“1835. Monetary gain from knowing and unlawful obtaining of protected health  
 information.

“1836. Knowing and unlawful use or disclosure of protected health information.

“1837. Monetary gain from knowing and unlawful sale, transfer, or use of pro-  
 tected health information.

18   **“§ 1831. Definitions**

19          “As used in this chapter—

1 “(1) the term ‘health information trustee’ has  
2 the meaning given such term in section 6400(b)(5)  
3 of the Bipartisan Health Care Reform Act of 1994;

4 “(2) the term ‘protected health information’ has  
5 the meaning given such term in section 6400(a)(3)  
6 of such Act; and

7 “(3) the term ‘protected individual’ has the  
8 meaning given such term in section 6400(a)(4) of  
9 such Act.

10 **“§ 1832. Obtaining protected health information**  
11 **under false pretenses**

12 “Whoever under false pretenses—

13 “(1) requests or obtains protected health infor-  
14 mation from a health information trustee; or

15 “(2) obtains from a protected individual an au-  
16 thorization for the disclosure of protected health in-  
17 formation about the individual maintained by a  
18 health information trustee;

19 shall be fined under this title or imprisoned not more than  
20 5 years, or both.

21 **“§ 1833. Monetary gain from obtaining protected**  
22 **health information under false pretenses**

23 “Whoever under false pretenses—

24 “(1) requests or obtains protected health infor-  
25 mation from a health information trustee with the



1 intent to sell, transfer, or use such information for  
2 profit or monetary gain; or

3 “(2) obtains from a protected individual an au-  
4 thorization for the disclosure of protected health in-  
5 formation about the individual maintained by a  
6 health information trustee with the intent to sell,  
7 transfer, or use such authorization for profit or  
8 monetary gain;

9 and knowingly sells, transfers, or uses such information  
10 or authorization for profit or monetary gain shall be fined  
11 under this title or imprisoned not more than 10 years, or  
12 both.

13 **“§ 1834. Knowing and unlawful obtaining of pro-**  
14 **ected health information**

15 “Whoever knowingly obtains protected health infor-  
16 mation from a health information trustee in violation of  
17 subtitle E of title VI of the Bipartisan Health Care Re-  
18 form Act of 1994, knowing that such obtaining is unlaw-  
19 ful, shall be fined under this title or imprisoned not more  
20 than 5 years, or both.

21 **“§ 1835. Monetary gain from knowing and unlawful**  
22 **obtaining of protected health information**

23 “Whoever knowingly—

24 “(1) obtains protected health information from  
25 a health information trustee in violation of subtitle

1 E of title VI of the Bipartisan Health Care Reform  
2 Act of 1994, knowing that such obtaining is unlaw-  
3 ful and with the intent to sell, transfer, or use such  
4 information for profit or monetary gain; and

5 “(2) knowingly sells, transfers, or uses such in-  
6 formation for profit or monetary gain;

7 shall be fined under this title or imprisoned not more than  
8 10 years, or both.

9 **“§ 1836. Knowing and unlawful use or disclosure of**  
10 **protected health information**

11 “Whoever knowingly uses or discloses protected  
12 health information in violation of subtitle E of title VI of  
13 the Bipartisan Health Care Reform Act of 1994, knowing  
14 that such use or disclosure is unlawful, shall be fined  
15 under this title or imprisoned not more than 5 years, or  
16 both.

17 **“§ 1837. Monetary gain from knowing and unlawful**  
18 **sale, transfer, or use of protected health**  
19 **information**

20 “Whoever knowingly sells, transfers, or uses pro-  
21 tected health information in violation of subtitle E of title  
22 VI of the Bipartisan Health Care Reform Act of 1994,  
23 knowing that such sale, transfer, or use is unlawful, shall  
24 be fined under this title or imprisoned not more than 10  
25 years, or both.”.

1 (b) CLERICAL AMENDMENT.—The table of chapters  
2 for part I of title 18, United States Code, is amended by  
3 inserting after the item relating to chapter 89 the follow-  
4 ing:

“90. Protected health information ..... 1831”.

5 **PART 6—AMENDMENTS TO TITLE 5, UNITED**  
6 **STATES CODE**

7 **SEC. 6461. AMENDMENTS TO TITLE 5, UNITED STATES**  
8 **CODE.**

9 (a) NEW SUBSECTION.—Section 552a of title 5,  
10 United States Code, is amended by adding at the end the  
11 following:

12 “(w) MEDICAL EXEMPTIONS.—The head of an agen-  
13 cy that is a health information trustee (as defined in sec-  
14 tion 6400(b)(5) of the Bipartisan Health Care Reform Act  
15 of 1994) shall promulgate rules, in accordance with the  
16 requirements (including general notice) of subsections  
17 (b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this  
18 title, to exempt a system of records within the agency, to  
19 the extent that the system of records contains protected  
20 health information (as defined in section 6400(a)(3) of  
21 such Act), from all provisions of this section except sub-  
22 sections (e)(1), (e)(2), subparagraphs (A) through (C) and  
23 (E) through (I) of subsection (e)(4), and subsections

1 (e)(5), (e)(6), (e)(9), (e)(12), (l), (n), (o), (p), (q), (r), and  
2 (u).”.

3 (b) REPEAL.—Section 552a(f)(3) of title 5, United  
4 States Code, is amended by striking “pertaining to him,”  
5 and all that follows through the semicolon and inserting  
6 “pertaining to the individual;”.

7 **PART 7—REGULATIONS, RESEARCH, AND EDU-**  
8 **CATION; EFFECTIVE DATES; APPLICABILITY;**  
9 **AND RELATIONSHIP TO OTHER LAWS**

10 **SEC. 6471. REGULATIONS; RESEARCH AND EDUCATION.**

11 (a) REGULATIONS.—Not later than July 1, 1996, the  
12 Secretary shall prescribe regulations to carry out this sub-  
13 title.

14 (b) RESEARCH AND TECHNICAL SUPPORT.—The  
15 Secretary may sponsor—

16 (1) research relating to the privacy and security  
17 of protected health information;

18 (2) the development of consent forms governing  
19 disclosure of such information; and

20 (3) the development of technology to implement  
21 standards regarding such information.

22 (c) EDUCATION.—The Secretary shall establish edu-  
23 cation and awareness programs—

24 (1) to foster adequate security practices by  
25 health information trustees;

1           (2) to train personnel of health information  
2       trustees respecting the duties of such personnel with  
3       respect to protected health information; and

4           (3) to inform individuals and employers who  
5       purchase health care respecting their rights with re-  
6       spect to such information.

7   **SEC. 6472. EFFECTIVE DATES.**

8       (a) IN GENERAL.—Except as provided in subsection  
9       (b), this subtitle, and the amendments made by this sub-  
10      title, shall take effect on January 1, 1997.

11      (b) PROVISIONS EFFECTIVE IMMEDIATELY.—A pro-  
12      vision of this subtitle shall take effect on the date of the  
13      enactment of this Act if the provision—

14           (1) imposes a duty on the Secretary to develop,  
15       establish, or promulgate regulations, guidelines, no-  
16       tices, statements, or education and awareness pro-  
17       grams; or

18           (2) authorizes the Secretary to sponsor research  
19       or the development of forms or technology.

20   **SEC. 6473. APPLICABILITY.**

21      (a) PROTECTED HEALTH INFORMATION.—Except as  
22      provided in subsections (b) and (c), the provisions of this  
23      subtitle shall apply to any protected health information  
24      that is received, created, used, maintained, or disclosed by  
25      a health information trustee in a State on or after Janu-

1 ary 1, 1997, regardless of whether the information existed  
2 or was disclosed prior to such date.

3 (b) EXCEPTION.—

4 (1) IN GENERAL.—The provisions of this sub-  
5 title shall not apply to a trustee described in para-  
6 graph (2), except with respect to protected health in-  
7 formation that is received by the trustee on or after  
8 January 1, 1997.

9 (2) APPLICABILITY.—A trustee referred to in  
10 paragraph (1) is—

11 (A) a health researcher; or

12 (B) a person who, with respect to specific  
13 protected health information, received the  
14 information—

15 (i) pursuant to—

16 (I) section 6417 (relating to  
17 emergency circumstances);

18 (II) section 6418 (relating to ju-  
19 dicial and administrative purposes);

20 (III) section 6419 (relating to  
21 law enforcement); or

22 (IV) section 6420 (relating to  
23 subpoenas, warrants, and search war-  
24 rants); or

1 (ii) while acting in whole or in part in  
2 the capacity of an officer or employee of a  
3 person described in clause (i).

4 (c) AUTHORIZATIONS FOR DISCLOSURES.—An au-  
5 thorization for the disclosure of protected health informa-  
6 tion about a protected individual that is executed by the  
7 individual before January 1, 1997, and is recognized and  
8 valid under State law on December 31, 1996, shall remain  
9 valid and shall not be subject to the requirements of sec-  
10 tion 6412 until January 1, 1998, or the occurrence of the  
11 date or event (if any) specified in the authorization upon  
12 which the authorization expires, whichever occurs earlier.

13 **SEC. 6474. RELATIONSHIP TO OTHER LAWS.**

14 (a) STATE LAW.—Except as otherwise provided in  
15 subsections (b), (c), (d), and (f), a State may not estab-  
16 lish, continue in effect, or enforce any State law to the  
17 extent that the law is inconsistent with, or imposes addi-  
18 tional requirements with respect to, any of the following:

19 (1) A duty of a health information trustee  
20 under this subtitle.

21 (2) An authority of a health information trustee  
22 under this subtitle to disclose protected health infor-  
23 mation.

1           (3) A provision of part 3 (relating to access  
2       procedures and challenge rights), part 4 (miscellane-  
3       ous provisions), or part 5 (relating to enforcement).

4       (b) LAWS RELATING TO PUBLIC HEALTH AND MEN-  
5       TAL HEALTH.—This subtitle does not preempt, supersede,  
6       or modify the operation of any State law regarding public  
7       health or mental health to the extent that the law prohibits  
8       or regulates a disclosure of protected health information  
9       that is permitted under this subtitle.

10       (c) CRIMINAL PENALTIES.—A State may establish  
11       and enforce criminal penalties with respect to a failure to  
12       comply with a provision of this subtitle.

13       (d) PRIVILEGES.—A privilege that a person has  
14       under law in a court of a State or the United States or  
15       under the rules of any agency of a State or the United  
16       States may not be diminished, waived, or otherwise af-  
17       fected by—

18           (1) the execution by a protected individual of an  
19       authorization for disclosure of protected health in-  
20       formation under this subtitle, if the authorization is  
21       executed for the purpose of receiving health care or  
22       providing for the payment for health care; or

23           (2) any provision of this subtitle that authorizes  
24       the disclosure of protected health information for the



1       purpose of receiving health care or providing for the  
2       payment for health care.

3       (e) DEPARTMENT OF VETERANS AFFAIRS.—The lim-  
4       itations on use and disclosure of protected health informa-  
5       tion under this subtitle shall not be construed to prevent  
6       any exchange of such information within and among com-  
7       ponents of the Department of Veterans Affairs that deter-  
8       mine eligibility for or entitlement to, or that provide, bene-  
9       fits under laws administered by the Secretary of Veterans  
10      Affairs.

11      (f) CERTAIN DUTIES UNDER STATE OR FEDERAL  
12      LAW.—This subtitle shall not be construed to preempt,  
13      supersede, or modify the operation of any of the following:

14           (1) Any law that provides for the reporting of  
15           vital statistics such as birth or death information.

16           (2) Any law requiring the reporting of abuse or  
17           neglect information about any individual.

18           (3) Subpart II of part E of title XXVI of the  
19           Public Health Service Act (relating to notifications  
20           of emergency response employees of possible expo-  
21           sure to infectious diseases).

22           (4) The Americans with Disabilities Act of  
23           1990.

1           (5) Any Federal or State statute that estab-  
2           lishes a privilege for records used in health profes-  
3           sional peer review activities.

4           (g) SECRETARIAL AUTHORITY.—

5           (1) SECRETARY OF HEALTH AND HUMAN SERV-  
6           ICES.—A provision of this subtitle does not preempt,  
7           supersede, or modify the operation of section 543 of  
8           the Public Health Service Act, except to the extent  
9           that the Secretary of Health and Human Services  
10          determines through regulations promulgated by such  
11          Secretary that the provision provides greater protec-  
12          tion for protected health information, and the rights  
13          of protected individuals, than is provided under such  
14          section 543.

15          (2) SECRETARY OF VETERANS AFFAIRS.—A  
16          provision of this subtitle does not preempt, super-  
17          secede, or modify the operation of section 7332 of title  
18          38, United States Code, except to the extent that  
19          the Secretary of Veterans Affairs determines  
20          through regulations promulgated by such Secretary  
21          that the provision provides greater protection for  
22          protected health information, and the rights of pro-  
23          tected individuals, than is provided under such sec-  
24          tion 7332.

## **Subtitle F—Antitrust**

### **SEC. 6501. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.**

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facilitate development and operation of plans, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which the administrator or sponsor of a health plan (or organization that proposes to administer or sponsor a health plan) may submit a request to the Attorney General to obtain a prompt opinion (but in no event later than 90 days after the Attorney General receives the request) from the Department of Justice on the plan’s conformity with the Federal antitrust laws.

(c) DEFINITIONS.—In this section—

(1) the term “antitrust laws”—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act

1 (15 U.S.C. 45) to the extent such section ap-  
2 plies to unfair methods of competition, and

3 (B) includes any State law similar to the  
4 laws referred to in subparagraph (A); and

5 (2) the term “health plan” means any contract  
6 or arrangement under which an entity bears all or  
7 part of the cost of providing health care items and  
8 services, including a hospital or medical expense in-  
9 curred policy or certificate, hospital or medical serv-  
10 ice plan contract, or health maintenance subscriber  
11 contract, but does not include—

12 (A) coverage only for accident, dental, vi-  
13 sion, disability, or long term care, medicare  
14 supplemental health insurance, or any combina-  
15 tion thereof,

16 (B) coverage issued as a supplement to li-  
17 ability insurance,

18 (C) workers’ compensation or similar in-  
19 surance, or

20 (D) automobile medical-payment insur-  
21 ance.

22 **SEC. 6502. ISSUANCE OF HEALTH CARE CERTIFICATES OF**  
23 **PUBLIC ADVANTAGE.**

24 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The  
25 Attorney General, after consultation with the Secretary,

1 shall issue in accordance with this section a certificate of  
2 public advantage to each eligible health care collaborative  
3 activity that complies with the requirements in effect  
4 under this section on or after the expiration of the 1-year  
5 period that begins on the date of the enactment of this  
6 Act (without regard to whether or not the Attorney Gen-  
7 eral has promulgated regulations to carry out this section  
8 by such date). Such activity, and the parties to such activ-  
9 ity, shall not be liable under any of the antitrust laws for  
10 conduct described in such certificate and engaged in by  
11 such activity if such conduct occurs while such certificate  
12 is in effect.

13 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF  
14 CERTIFICATES.—

15 (1) STANDARDS TO BE MET.—The Attorney  
16 General shall issue a certificate to an eligible health  
17 care collaborative activity if the Attorney General  
18 finds that—

19 (A) the benefits that are likely to result  
20 from carrying out the activity outweigh the re-  
21 duction in competition (if any) that is likely to  
22 result from the activity, and

23 (B) such reduction in competition is nec-  
24 essary to obtain such benefits.

25 (2) FACTORS TO BE CONSIDERED.—

1 (A) WEIGHING OF BENEFITS AGAINST RE-  
2 Duction IN COMPETITION.—For purposes of  
3 making the finding described in paragraph  
4 (1)(A), the Attorney General shall consider  
5 whether the activity is likely—

6 (i) to maintain or to increase the  
7 quality of health care by providing new  
8 services not currently offered in the rel-  
9 evant market,

10 (ii) to increase access to health care,

11 (iii) to achieve cost efficiencies that  
12 will be passed on to health care consumers,  
13 such as economies of scale, reduced trans-  
14 action costs, and reduced administrative  
15 costs, that cannot be achieved by the provi-  
16 sion of available services and facilities in  
17 the relevant market,

18 (iv) to preserve the operation of  
19 health care facilities located in underserved  
20 geographical areas,

21 (v) to improve utilization of health  
22 care resources, and

23 (vi) to reduce inefficient health care  
24 resource duplication.

1 (B) NECESSITY OF REDUCTION IN COM-  
2 PETITION.—For purposes of making the finding  
3 described in paragraph (1)(B), the Attorney  
4 General shall consider—

5 (i) the ability of the providers of  
6 health care services that are (or likely to  
7 be) affected by the health care collabo-  
8 rative activity and the entities responsible  
9 for making payments to such providers to  
10 negotiate societally optimal payment and  
11 service arrangements,

12 (ii) the effects of the health care col-  
13 laborative activity on premiums and other  
14 charges imposed by the entities described  
15 in clause (i), and

16 (iii) the availability of equally effi-  
17 cient, less restrictive alternatives to achieve  
18 the benefits that are intended to be  
19 achieved by carrying out the activity.

20 (c) ESTABLISHMENT OF CRITERIA AND PROCE-  
21 DURES.—Subject to subsections (d) and (e), not later than  
22 1 year after the date of the enactment of this Act, the  
23 Attorney General and the Secretary shall establish jointly  
24 by rule the criteria and procedures applicable to the issu-  
25 ance of certificates under subsection (a). The rules shall

1 specify the form and content of the application to be sub-  
2 mitted to the Attorney General to request a certificate,  
3 the information required to be submitted in support of  
4 such application, the procedures applicable to denying and  
5 to revoking a certificate, and the procedures applicable to  
6 the administrative appeal (if such appeal is authorized by  
7 rule) of the denial and the revocation of a certificate. Such  
8 information may include the terms of the health care col-  
9 laborative activity (in the case of an activity in existence  
10 as of the time of the application) and implementation plan  
11 for the collaborative activity.

12 (d) ELIGIBLE HEALTH CARE COLLABORATIVE AC-  
13 TIVITY.—To be an eligible health care collaborative activ-  
14 ity for purposes of this section, a health care collaborative  
15 activity shall submit to the Attorney General an applica-  
16 tion that complies with the rules in effect under subsection  
17 (c) and that includes—

18 (1) an agreement by the parties to the activity  
19 that the activity will not foreclose competition by en-  
20 tering into contracts that prevent health care provid-  
21 ers from providing health care in competition with  
22 the activity,

23 (2) an agreement that the activity will submit  
24 to the Attorney General annually a report that de-  
25 scribes the operations of the activity and information



1       regarding the impact of the activity on health care  
2       and on competition in health care, and

3           (3) an agreement that the parties to the activity  
4       will notify the Attorney General and the Secretary of  
5       the termination of the activity not later than 30  
6       days after such termination occurs.

7       (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—  
8       Not later than 90 days after an eligible health care col-  
9       laborative activity submits to the Attorney General an ap-  
10      plication that complies with the rules in effect under sub-  
11      section (c) and with subsection (d), the Attorney General  
12      shall issue or deny the issuance of such certificate. If, be-  
13      fore the expiration of such 90-day period, the Attorney  
14      General may extend the time for issuance for good cause.

15      (f) REVOCATION OF CERTIFICATE.—Whenever the  
16      Attorney General finds that a health care collaborative ac-  
17      tivity with respect to which a certificate is in effect does  
18      not meet the standards specified in subsection (b), the At-  
19      torney General shall revoke such certificate.

20      (g) WRITTEN REASONS; JUDICIAL REVIEW.—

21           (1) DENIAL AND REVOCATION OF CERTIFI-  
22      CATES.—If the Attorney General denies an applica-  
23      tion for a certificate or revokes a certificate, the At-  
24      torney General shall include in the notice of denial

1 or revocation a statement of the reasons relied upon  
2 for the denial or revocation of such certificate.

3 (2) JUDICIAL REVIEW.—

4 (A) AFTER ADMINISTRATIVE PROCEED-  
5 ING.—(i) If the Attorney General denies an ap-  
6 plication submitted or revokes a certificate is-  
7 sued under this section after an opportunity for  
8 hearing on the record, then any party to the  
9 health care collaborative activity involved may  
10 commence a civil action, not later than 60 days  
11 after receiving notice of the denial or revoca-  
12 tion, in an appropriate district court of the  
13 United States for review of the record of such  
14 denial or revocation.

15 (ii) As part of the Attorney General's an-  
16 swer, the Attorney General shall file in such  
17 court a certified copy of the record on which  
18 such denial or revocation is based. The findings  
19 of fact of the Attorney General may be set aside  
20 only if found to be unsupported by substantial  
21 evidence in such record taken as a whole.

22 (B) DENIAL OR REVOCATION WITHOUT AD-  
23 MINISTRATIVE PROCEEDING.—If the Attorney  
24 General denies an application submitted or re-  
25 vokes a certificate issued under this section

1           without an opportunity for hearing on the  
2           record, then any party to the health care col-  
3           laborative activity involved may commence a  
4           civil action, not later than 60 days after receiv-  
5           ing notice of the denial or revocation, in an ap-  
6           propriate district court of the United States for  
7           de novo review of such denial or revocation.

8           (h) EXEMPTION.—A person shall not be liable under  
9 any of the antitrust laws for conduct necessary—

10           (1) to prepare, agree to prepare, or attempt to  
11           agree to prepare an application to request a certifi-  
12           cate under this section, or

13           (2) to attempt to enter into any health care col-  
14           laborative activity with respect to which such a cer-  
15           tificate is in effect.

16           (i) DEFINITIONS.—In this section:

17           (1) The term “antitrust laws” has the meaning  
18           given it in section 6501(c)(1).

19           (2) The term “certificate” means a certificate  
20           of public advantage authorized to be issued under  
21           subsection (a).

22           (3) The term “health care collaborative activ-  
23           ity” means an agreement (whether existing or pro-  
24           posed) between 2 or more providers of health care  
25           services that is entered into solely for the purpose of

1 sharing in the provision and coordination of health  
2 care services and that involves substantial integra-  
3 tion and financial risk-sharing between the parties,  
4 but does not include the exchanging of information,  
5 the entering into of any agreement, or the engage-  
6 ment in any other conduct that is not reasonably re-  
7 quired to carry out such agreement.

8 (4) The term “health care services” includes  
9 services related to the delivery or administration of  
10 health care services.

11 (5) The term “liable” means liable for any civil  
12 or criminal violation of the antitrust laws.

13 (6) The term “provider of health care services”  
14 means any individual or entity that is engaged in the  
15 delivery of health care services in a State and that  
16 is required by State law or regulation to be licensed  
17 or certified by the State to engage in the delivery of  
18 such services in the State.

19 **SEC. 6503. STUDY OF IMPACT ON COMPETITION.**

20 The Attorney General, in consultation with the Chair-  
21 man of the Federal Trade Commission, annually shall sub-  
22 mit to the Congress a report as part of the annual budget  
23 oversight proceedings concerning the Antitrust Division of  
24 the Department of Justice. The report shall enable the  
25 Congress to determine how enforcement of antitrust laws

1 is affecting the formation of efficient, cost-saving joint  
2 ventures and if the certificate of public advantage proce-  
3 dure set forth in section 6502 has resulted in undesirable  
4 reduction in competition in the health care marketplace.  
5 The report shall include an evaluation of the factors set  
6 forth in paragraphs (2)(A) and (2)(B) of section 6502(b).

## 7       **Subtitle G—Fraud and Abuse**

### 8       **PART    1—ESTABLISHMENT    OF    ALL-PAYER** 9       **HEALTH CARE FRAUD AND ABUSE CONTROL** 10      **PROGRAM**

#### 11      **SEC. 6601. ALL-PAYER HEALTH CARE FRAUD AND ABUSE** 12                           **CONTROL PROGRAM.**

13           (a) IN GENERAL.—Not later than January 1, 1996,  
14 the Attorney General shall establish a program—

15               (1) to coordinate Federal, State, and local law  
16 enforcement programs to control fraud and abuse  
17 with respect to the delivery of and payment for  
18 health care in the United States,

19               (2) to conduct investigations, audits, evalua-  
20 tions, and inspections relating to the delivery of and  
21 payment for health care in the United States, and

22               (3) in consultation with the Inspector General  
23 of the Department of Health and Human Services,  
24 to facilitate the enforcement of the provisions of sec-  
25 tions 1128, 1128A, and 1128B of the Social Secu-

1        rity Act and other statutes applicable to health care  
2        fraud and abuse.

3        (b) COORDINATION WITH LAW ENFORCEMENT  
4 AGENCIES.—In carrying out the program under sub-  
5 section (a), the Attorney General shall consult with, and  
6 arrange for the sharing of data and resources with Fed-  
7 eral, State and local law enforcement agencies, State Med-  
8 icaid Fraud Control Units, and State agencies responsible  
9 for the licensing and certification of health care providers.

10        (c) COORDINATION WITH THIRD PARTY INSUR-  
11 ERS.—In carrying out the program established under sub-  
12 section (a), the Attorney General shall consult with, and  
13 arrange for the sharing of data with representatives of pri-  
14 vate sponsors of health benefit plans and other providers  
15 of health insurance.

16        (d) REGULATIONS.—

17            (1) IN GENERAL.—The Attorney General shall  
18        by regulation establish standards to carry out the  
19        program under subsection (a).

20            (2) INFORMATION STANDARDS.—

21            (A) IN GENERAL.—Such standards shall  
22        include standards relating to the furnishing of  
23        information by health insurers (including self-  
24        insured health benefit plans), providers, and  
25        others to enable the Attorney General to carry

1 out the program (including coordination with  
2 law enforcement agencies under subsection (b)  
3 and third party insurers under subsection (c)).

4 (B) CONFIDENTIALITY.—Such standards  
5 shall include procedures to assure that such in-  
6 formation is provided and utilized in a manner  
7 that protects the confidentiality of the informa-  
8 tion and the privacy of individuals receiving  
9 health care services.

10 (C) QUALIFIED IMMUNITY FOR PROVIDING  
11 INFORMATION.—The provisions of section  
12 1157(a) of the Social Security Act (relating to  
13 limitation on liability) shall apply to a person  
14 providing information to the Attorney General  
15 under the program under this section, with re-  
16 spect to the Attorney General's performance of  
17 duties under the program, in the same manner  
18 as such section applies to information provided  
19 to organizations with a contract under part B  
20 of title XI of such Act, with respect to the per-  
21 formance of such a contract.

1 **SEC. 6602. AUTHORIZATION OF ADDITIONAL APPROPRIA-**  
2 **TIONS FOR INVESTIGATORS AND OTHER PER-**  
3 **SONNEL.**

4 In addition to any other amounts authorized to be  
5 appropriated to the Attorney General for health care anti-  
6 fraud and abuse activities for a fiscal year, there are au-  
7 thorized to be appropriated such sums as may be nec-  
8 essary to enable the Attorney General to conduct inves-  
9 tigations of allegations of health care fraud and otherwise  
10 carry out the program established under section 6601 in  
11 a fiscal year.

12 **SEC. 6603. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE**  
13 **TRUST FUND.**

14 (a) ESTABLISHMENT.—There is hereby created on  
15 the books of the Treasury of the United States a trust  
16 fund to be known as the “Anti-Fraud and Abuse Trust  
17 Fund” (in this section referred to as the “Trust Fund”).  
18 The Trust Fund shall consist of such amounts as may be  
19 deposited in, or appropriated to, such Trust Fund as pro-  
20 vided in this part and section 1128A(f)(3) of the Social  
21 Security Act.

22 (b) MANAGEMENT.—

23 (1) IN GENERAL.—The Trust Fund shall be  
24 managed by the Attorney General through a Manag-  
25 ing Trustee designated by the Attorney General.



1           (2) INVESTMENT OF FUNDS.—It shall be the  
2       duty of the Managing Trustee to invest such portion  
3       of the Trust Fund as is not, in the trustee's judg-  
4       ment, required to meet current withdrawals. Such  
5       investments may be made only in interest-bearing  
6       obligations of the United States or in obligations  
7       guaranteed as to both principal and interest by the  
8       United States. For such purpose such obligations  
9       may be acquired on original issue at the issue price,  
10      or by purchase of outstanding obligations at market  
11      price. The purposes for which obligations of the  
12      United States may be issued under chapter 31 of  
13      title 31, United States Code, are hereby extended to  
14      authorize the issuance at par of public-debt obliga-  
15      tions for purchase by the Trust Fund. Such obliga-  
16      tions issued for purchase by the Trust Fund shall  
17      have maturities fixed with due regard for the needs  
18      of the Trust Fund and shall bear interest at a rate  
19      equal to the average market yield (computed by the  
20      Managing Trustee on the basis of market quotations  
21      as of the end of the calendar month next preceding  
22      the date of such issue) on all marketable interest-  
23      bearing obligations of the United States then form-  
24      ing a part of the public debt which are not due or  
25      callable until after the expiration of 4 years from the

1       end of such calendar month, except that where such  
2       average is not a multiple of  $\frac{1}{8}$  of 1 percent, the rate  
3       of interest on such obligations shall be the multiple  
4       of  $\frac{1}{8}$  of 1 percent nearest such market yield. The  
5       Managing Trustee may purchase other interest-bear-  
6       ing obligations of the United States or obligations  
7       guaranteed as to both principal and interest by the  
8       United States, on original issue or at the market  
9       price, only where the Trustee determines that the  
10      purchase of such other obligations is in the public  
11      interest.

12           (3) Any obligations acquired by the Trust Fund  
13      (except public-debt obligations issued exclusively to  
14      the Trust Fund) may be sold by the Managing  
15      Trustee at the market price, and such public-debt  
16      obligations may be redeemed at par plus accrued in-  
17      terest.

18           (4) The interest on, and the proceeds from the  
19      sale or redemption of, any obligations held in the  
20      Trust Fund shall be credited to and form a part of  
21      the Trust Fund.

22           (5) The receipts and disbursements of the At-  
23      torney General in the discharge of the functions of  
24      the Attorney General shall not be included in the to-  
25      tals of the budget of the United States Government.

1 For purposes of part C of the Balanced Budget and  
2 Emergency Deficit Control Act of 1985, the Attor-  
3 ney General and the Trust Fund shall be treated in  
4 the same manner as the Federal Retirement Thrift  
5 Investment Board and the Thrift Savings Fund, re-  
6 spectively. The United States is not liable for any  
7 obligation or liability incurred by the Trust Fund.

8 (c) USE OF FUNDS.—Of the amounts in the Trust  
9 Fund—

10 (1) not less than 60 percent shall be used to  
11 support educational activities to prevent the occur-  
12 rence of violations of anti-fraud and abuse laws, in-  
13 cluding the issuance of advisory opinions under sec-  
14 tion 1129 and 1877(i) of the Social Security Act (as  
15 added by part 4) and fraud alerts, seminars for pro-  
16 viders, and program updates; and

17 (2) any amounts remaining after use for activi-  
18 ties under paragraph (1) shall be used to assist the  
19 Attorney General in carrying out the all-payer fraud  
20 and abuse control program established under section  
21 6601(a) in the fiscal year involved.

22 (d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD  
23 AND ABUSE PENALTIES INTO TRUST FUND.—Section  
24 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a-  
25 7a(f)(3)) is amended by striking “as miscellaneous re-

1 cepts of the Treasury of the United States” and inserting  
2 “in the Anti-Fraud and Abuse Trust Fund established  
3 under section 6603(a) of the Bipartisan Health Care Re-  
4 form Act of 1994”.

5 (e) USE OF FEDERAL HEALTH ANTI-FRAUD AND  
6 ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-  
7 SHARING.—Section 1128A(f) of the Social Security Act  
8 (42 U.S.C. 1320a–7a(f)) is amended in the matter preced-  
9 ing paragraph (1) by striking “Secretary and disposed of  
10 as follows:” and inserting the following: “Secretary. If the  
11 person against whom such a penalty or assessment was  
12 assessed collected a payment from an individual for pro-  
13 viding to the individual the service that is the subject of  
14 the penalty or assessment, the Secretary shall pay a por-  
15 tion of the amount recovered to the individual in the na-  
16 ture of restitution in an amount equal to the payment so  
17 collected. The Secretary shall dispose of any remaining  
18 amounts recovered under this section as follows:”.

19 **PART 2—REVISIONS TO CURRENT SANCTIONS**  
20 **FOR FRAUD AND ABUSE**

21 **SEC. 6611. MANDATORY EXCLUSION FROM PARTICIPATION**  
22 **IN MEDICARE AND STATE HEALTH CARE PRO-**  
23 **GRAMS.**

24 (a) INDIVIDUAL CONVICTED OF FELONY RELATING  
25 TO FRAUD.—

1           (1) IN GENERAL.—Section 1128(a) of the So-  
2       cial Security Act (42 U.S.C. 1320a–7(a)) is amend-  
3       ed by adding at the end the following new para-  
4       graph:

5           “(3) FELONY CONVICTION RELATING TO  
6       FRAUD.—Any individual or entity that has been con-  
7       victed, under Federal or State law, in connection  
8       with the delivery of a health care item or service on  
9       or after the date of the enactment of this paragraph,  
10      or with respect to any act or omission on or after  
11      such date in a program (other than those specifically  
12      described in paragraph (1)) operated by or financed  
13      in whole or in part by any Federal, State, or local  
14      government agency, of a criminal offense consisting  
15      of a felony relating to fraud, theft, embezzlement,  
16      breach of fiduciary responsibility, or other financial  
17      misconduct.”.

18          (2) CONFORMING AMENDMENT.—Section  
19      1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1))  
20      is amended—

21           (A) in the heading, by striking “CONVIC-  
22           TION” and inserting “MISDEMEANOR CONVIC-  
23           TION”; and

1 (B) by striking “criminal offense” and in-  
2 sserting “criminal offense consisting of a mis-  
3 demeanor”.

4 (b) INDIVIDUAL CONVICTED OF FELONY RELATING  
5 TO CONTROLLED SUBSTANCE.—

6 (1) IN GENERAL.—Section 1128(a) of the So-  
7 cial Security Act (42 U.S.C. 1320a–7(a)), as amend-  
8 ed by subsection (a), is amended by adding at the  
9 end the following new paragraph:

10 “(4) FELONY CONVICTION RELATING TO CON-  
11 TROLLED SUBSTANCE.—Any individual or entity  
12 that has been convicted, under Federal or State law,  
13 of a criminal offense consisting of a felony relating  
14 to the unlawful manufacture, distribution, prescrip-  
15 tion, or dispensing of a controlled substance.”.

16 (2) CONFORMING AMENDMENT.—Section  
17 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3))  
18 is amended—

19 (A) in the heading, by striking “CONVIC-  
20 TION” and inserting “MISDEMEANOR CONVIC-  
21 TION”; and

22 (B) by striking “criminal offense” and in-  
23 sserting “criminal offense consisting of a mis-  
24 demeanor”.

1 **SEC. 6612. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**  
2 **CLUSION FOR CERTAIN INDIVIDUALS AND**  
3 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**  
4 **SION FROM MEDICARE AND STATE HEALTH**  
5 **CARE PROGRAMS.**

6 Section 1128(c)(3) of the Social Security Act (42  
7 U.S.C. 1320a–7(c)(3)) is amended by adding at the end  
8 the following new subparagraphs:

9 “(D) In the case of an exclusion of an individual or  
10 entity under paragraph (1), (2), or (3) of subsection (b),  
11 the period of the exclusion shall be 3 years, unless the  
12 Secretary determines in accordance with published regula-  
13 tions that a shorter period is appropriate because of miti-  
14 gating circumstances or that a longer period is appro-  
15 priate because of aggravating circumstances.

16 “(E) In the case of an exclusion of an individual or  
17 entity under subsection (b)(4) or (b)(5), the period of the  
18 exclusion shall not be less than the period during which  
19 the individual’s or entity’s license to provide health care  
20 is revoked, suspended, or surrendered, or the individual  
21 or the entity is excluded or suspended from a Federal or  
22 State health care program.

23 “(F) In the case of an exclusion of an individual or  
24 entity under subsection (b)(6)(B), the period of the exclu-  
25 sion shall be not less than 1 year.”.

1 **SEC. 6613. REVISIONS TO CRIMINAL PENALTIES.**

2 (a) CLARIFICATION OF DISCOUNT EXCEPTION TO  
3 ANTI-KICKBACK PROVISIONS.—Section 1128B(b)(3)(A)  
4 of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)(A))  
5 is amended—

6 (1) by inserting “(regardless of its timing or  
7 availability)” after “in price”; and

8 (2) by striking “program;” and inserting “pro-  
9 gram and is not paid in the form of currency or  
10 coin;”.

11 (b) EXEMPTION FROM ANTI-KICKBACK PENALTIES  
12 FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section  
13 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)) is  
14 amended—

15 (1) by striking “and” at the end of subpara-  
16 graph (D);

17 (2) by striking the period at the end of sub-  
18 paragraph (E) and inserting “; and”; and

19 (3) by adding at the end the following new sub-  
20 paragraph:

21 “(F) any reduction in cost sharing or increased  
22 benefits given to an individual, any amounts paid to  
23 a provider for an item or service furnished to an in-  
24 dividual, or any discount or reduction in price given  
25 by the provider for such an item or service, if—



1           “(A) the item or service is provided  
2           through an organization described in section  
3           1877(b)(3), or

4           “(B) the item or service is provided  
5           through such an organization on behalf of an-  
6           other entity (including but not limited to a self-  
7           insured employer or indemnity plan) that as-  
8           sumes financial risk for the provision of the  
9           item or service.”.

10       (c) EXEMPTION FROM ANTI-KICKBACK PENALTIES  
11       FOR CERTAIN PROTECTED FINANCIAL RELATIONSHIPS.—  
12       Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-  
13       7b(b)(3)), as amended by subsection (b), is further  
14       amended—

15           (1) by striking “and” at the end of subpara-  
16       graph (E);

17           (2) by striking the period at the end of sub-  
18       paragraph (F) and inserting “; and”; and

19           (3) by adding at the end the following new sub-  
20       paragraph:

21           “(G) any amount in a financial relationship of  
22       a physician (or an immediate family member of such  
23       physician) with an entity specified in section  
24       1877(a)(2), if section 1877(a)(1) does not apply to  
25       that amount or financial relationship.”.

1       (d) EXEMPTION FROM ANTI-KICKBACK PENALTIES  
2 FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT  
3 MEDICALLY UNDERSERVED PERSONS.—

4           (1) IN GENERAL.—Section 1128B(b)(3) of such  
5 Act (42 U.S.C. 1320a–7b(b)(3)), as amended by  
6 subsections (b) and (c), is further amended—

7           (A) by striking “and” at the end of sub-  
8 paragraph (F);

9           (B) by striking the period at the end of  
10 subparagraph (G) and inserting “; and”; and

11           (C) by adding at the end the following new  
12 subparagraph:

13           “(F) any remuneration paid by or to a re-  
14 cipient or subrecipient of Federal grant funds  
15 under or in connection with an arrangement for  
16 the procurement of goods or services by the re-  
17 cipient or subrecipient, the referral of patients,  
18 or the lease or purchase of space or equipment,  
19 if—

20           “(i) the arrangement is in writing and  
21 signed by the parties;

22           “(ii) the arrangement will result in  
23 the savings of Federal grant funds or in-  
24 creased revenues to the recipient or sub-  
25 recipient that will be used to increase the

1 availability or accessibility of services to a  
2 medically underserved population served by  
3 the recipient or subrecipient or an im-  
4 provement in the quality of services to  
5 such population, except that the recipient  
6 or subrecipient may seek a prior deter-  
7 mination from the Public Health Service  
8 that this requirement is met and, if the re-  
9 cipient or subrecipient does so, Public  
10 Health Service approval shall be conclusive  
11 and binding on the Federal Government;

12 “(iii) the arrangement will not result  
13 in private inurement to any current em-  
14 ployees or members of the Board of Direc-  
15 tors of the recipient or subrecipient, or to  
16 agents of the recipient or subrecipient who  
17 were involved in recommending or nego-  
18 tiating the arrangement;

19 “(iv) with respect to an arrangement  
20 under which a recipient or subrecipient is  
21 procuring goods or services, the provider of  
22 the goods or services is the only provider  
23 able to supply such goods or services, or  
24 the recipient or subrecipient has engaged  
25 in a competitive process to procure the

1 goods or services that meets the require-  
2 ments for competition under Federal grant  
3 awards;

4 “(v) with respect to an arrangement  
5 for a referral of patients, the arrangement  
6 will assure that all patients covered or af-  
7 fected by the arrangement are advised that  
8 they may request a referral to any person  
9 or entity of their choosing, subject to ap-  
10 propriate contractual limitations under  
11 which the recipient or subrecipient may op-  
12 erate as a health plan or as a contract  
13 health plan provider and such limitations  
14 as the patient may be under as an enrollee  
15 of a health plan;

16 “(vi) with respect to an arrangement  
17 for a referral of patients, the arrangement  
18 will not interfere with the discretion of  
19 health professionals to refer patients in a  
20 manner they believe will most appro-  
21 priately deal with a patient’s particular cir-  
22 cumstances, subject to appropriate con-  
23 tractual limitations under which the recipi-  
24 ent or subrecipient may operate as a  
25 health plan or as a contract health plan

1 provider and such limitations as the pa-  
2 tient may be under as an enrollee of a  
3 health plan; and

4 “(vii) with respect to an arrangement  
5 that does not meet the requirements of any  
6 of the preceding clauses, the recipient or  
7 subrecipient of Federal grant funds in-  
8 volved has applied to the Secretary for ap-  
9 proval of the arrangement and the Sec-  
10 retary, after consultation with the Inspec-  
11 tor General of the Department of Health  
12 and Human Services, has approved the ar-  
13 rangement based upon a finding that the  
14 arrangement will produce a substantial  
15 benefit to a medically underserved popu-  
16 lation that outweighs the arrangement’s  
17 failure to fully satisfy all of the above re-  
18 quirements.

19 In this subparagraph, a ‘recipient’ means a  
20 public or nonprofit private entity that receives  
21 a grant or cooperative agreement under the  
22 Public Health Service Act or title V, and a  
23 ‘subrecipient’ means a public or nonprofit pri-  
24 vate entity that performs substantive work  
25 under a grant or cooperative agreement under

1 the Public Health Service Act or title V to a re-  
2 cipient.”.

3 (2) EFFECTIVE DATE.—The amendments made  
4 by paragraph (1) shall take effect after the expira-  
5 tion of the 6-month period that begins on the date  
6 of the enactment of this Act.

7 **SEC. 6615. REVISIONS TO LIMITATIONS ON PHYSICIAN**  
8 **SELF-REFERRAL.**

9 (a) CLARIFICATION OF COVERAGE OF RADIOLOGY OR  
10 DIAGNOSTIC SERVICES.—Section 1877(h)(6) of the Social  
11 Security Act (42 U.S.C. 1395nn(h)(6)) is amended by  
12 striking subparagraph (D).

13 (b) NEW EXCEPTION FOR SHARED FACILITY SERV-  
14 ICES.—Section 1877(b) of such Act (42 U.S.C.  
15 1395nn(b)) is amended—

16 (1) by redesignating paragraph (4) as para-  
17 graph (5); and

18 (2) by inserting after paragraph (3) the follow-  
19 ing new paragraph:

20 “(4) SHARED FACILITY SERVICES.—

21 “(A) IN GENERAL.—In the case of a  
22 shared facility service of a shared facility—

23 “(i) that is furnished—

24 “(I) personally by the referring  
25 physician who is a shared facility phy-

1           sician or personally by an individual  
2           directly employed or directly super-  
3           vised by such a physician,

4           “(II) by a shared facility in a  
5           building in which the referring physi-  
6           cian furnishes substantially all of the  
7           services of the physician that are un-  
8           related to the furnishing of shared fa-  
9           cility services, and

10          “(III) to a patient of a shared fa-  
11          cility physician; and

12          “(ii) that is billed by the referring  
13          physician.

14          “(B) SHARED FACILITY RELATED DEFINI-  
15          TIONS.—

16          “(i) SHARED FACILITY SERVICE.—  
17          The term ‘shared facility service’ means,  
18          with respect to a shared facility, a des-  
19          ignated health service furnished by the fa-  
20          cility to patients of shared facility physi-  
21          cians.

22          “(ii) SHARED FACILITY.—The term  
23          ‘shared facility’ means an entity that fur-  
24          nishes shared facility services under a  
25          shared facility arrangement.

1 “(iii) SHARED FACILITY PHYSICIAN.—

2 The term ‘shared facility physician’ means,  
3 with respect to a shared facility, a physi-  
4 cian who has a financial relationship under  
5 a shared facility arrangement with the fa-  
6 cility.

7 “(iv) SHARED FACILITY ARRANGE-  
8 MENT.—The term ‘shared facility arrange-  
9 ment’ means, with respect to the provision  
10 of shared facility services in a building, a  
11 financial arrangement—

12 “(I) which is only between physi-  
13 cians who are providing services (un-  
14 related to shared facility services) in  
15 the same building,

16 “(II) in which the overhead ex-  
17 penses of the facility are shared, in  
18 accordance with methods previously  
19 determined by the physicians in the  
20 arrangement, among the physicians in  
21 the arrangement, and

22 “(III) which, in the case of a cor-  
23 poration, is wholly owned and con-  
24 trolled by shared facility physicians.”.



1 (c) REVISION TO RURAL PROVIDER EXCEPTION.—  
2 Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2))  
3 is amended by striking “substantially all” and inserting  
4 “not less than 75 percent (as determined in accordance  
5 with regulations of the Secretary)”.

6 (d) CLARIFICATION OF REFERRALS BY  
7 NEPHROLOGISTS.—Section 1877(h)(5)(C) of such Act (42  
8 U.S.C. 1395nn(H)(5)(C)) is amended—

9 (1) by striking “and a request” and inserting  
10 “a request”;

11 (2) by inserting after “radiation therapy,” the  
12 following: “and a request by a nephrologist for items  
13 or services related to renal dialysis,”; and

14 (3) by striking “or radiation oncologist” and in-  
15 serting “radiation oncologist, or nephrologist”.

16 (e) REVISION OF REPORTING REQUIREMENTS.—Sec-  
17 tion 1877(f) of such Act (42 U.S.C. 1395nn(f)) is  
18 amended—

19 (1) by striking “Each entity” and all that fol-  
20 lows through paragraph (2) and inserting the follow-  
21 ing: “The Secretary may require each entity (other  
22 than a physician or physician group practice) provid-  
23 ing designated health services to provide the Sec-  
24 retary with the following information concerning the

1       entity’s ownership, investment, and compensation ar-  
2       rangements:

3           “(1) the designated health services provided by  
4       the entity; and

5           “(2) the names and unique physician identifier  
6       numbers of all physicians with an ownership or in-  
7       vestment interest (as described in subsection  
8       (a)(2)(A)) or with a compensation interest (as de-  
9       scribed in subsection (a)(2)(B)) in the entity, or  
10      whose immediate relatives have such an ownership,  
11      investment, or compensation interest in the entity.”;  
12      and

13           (2) by striking the fifth sentence.

14      (f) EXCEPTION FOR CERTAIN MANAGED CARE AR-  
15      RANGEMENTS.—Section 1877(b)(3) of such Act (42  
16      U.S.C. 1395nn(b)(3)) is amended—

17           (1) by striking “or” at the end of subparagraph  
18      (C);

19           (2) by striking the period at the end of sub-  
20      paragraph (D) and inserting a comma; and

21           (3) by adding at the end the following new sub-  
22      paragraphs:

23           “(E) with a contract with a State to pro-  
24      vide services under the State plan under title  
25      XIX (in accordance with section 1903(m)); or

1           “(F) which meets State regulatory require-  
2           ments applicable to health maintenance organi-  
3           zations and which—

4                   “(i) provides designated health serv-  
5                   ices directly or through contractual ar-  
6                   rangements with providers;

7                   “(ii) assumes financial risk for the  
8                   provision of services or provides services on  
9                   behalf of another individual or entity (in-  
10                  cluding but not limited to a self-insured  
11                  employer, indemnity plan, physician, or  
12                  physician group) that assumes financial  
13                  risk for the provision of the item or serv-  
14                  ice; and

15                  “(iii) subjects the services to a pro-  
16                  gram of utilization review offered by an or-  
17                  ganization described in a preceding sub-  
18                  paragraph, an organization meeting State  
19                  regulatory requirements applicable to utili-  
20                  zation review, or an organization accred-  
21                  ited to perform utilization review consid-  
22                  ered appropriate by the Secretary.”.

23           (g) PREEMPTION OF STATE LAW.—Section 1877(g)  
24   of such Act (42 U.S.C. 1395nn(g)) is amended by adding  
25   at the end the following new paragraph:

1           “(6) PREEMPTION OF STATE LAW.—The provi-  
2           sions of this section shall supersede any State law to  
3           the extent State law prohibits a physician from mak-  
4           ing a referral, or an entity from presenting a bill, for  
5           the furnishing of a service which is not subject to  
6           the restrictions applicable under paragraph (1).”.

7           (h) REVISION OF EFFECTIVE DATE EXCEPTION PRO-  
8           VISION.—Section 13562(b)(2) of the Omnibus Budget  
9           Reconciliation Act of 1993 is amended by striking sub-  
10          paragraphs (A) and (B) and inserting the following:

11                   “(A) the second sentence of subsection  
12                   (a)(2), and subsections (b)(2)(B) and (d)(2), of  
13                   section 1877 of the Social Security Act (as in  
14                   effect on the day before the date of the enact-  
15                   ment of this Act) shall apply instead of the cor-  
16                   responding provisions in section 1877 (as  
17                   amended by this Act);

18                   “(B) section 1877(b)(4) of the Social Se-  
19                   curity Act (as in effect on the day before the  
20                   date of the enactment of this Act) shall apply;

21                   “(C) the requirements of section  
22                   1877(c)(2) of the Social Security Act (as  
23                   amended by this Act) shall not apply to any se-  
24                   curities of a corporation that meets the require-  
25                   ments of section 1877(c)(2) of the Social Secu-

1           rity Act (as in effect on the day before the date  
2           of the enactment of this Act);

3           “(D) section 1877(e)(3) of the Social Secu-  
4           rity Act (as amended by this Act) shall apply,  
5           except that it shall not apply to any arrange-  
6           ment that meets the requirements of subsection  
7           (e)(2) or subsection (e)(3) of section 1877 of  
8           the Social Security Act (as in effect on the day  
9           before the date of the enactment of this Act);

10          “(E) the requirements of clauses (iv) and  
11          (v) of section 1877(h)(4)(A), and of clause (i)  
12          of section 1877(h)(4)(B), of the Social Security  
13          Act (as amended by this Act) shall not apply;  
14          and

15          “(F) section 1877(h)(4)(B) of the Social  
16          Security Act (as in effect on the day before the  
17          date of the enactment of this Act) shall apply  
18          instead of section 1877(h)(4)(A)(ii) of such Act  
19          (as amended by this Act).”.

20          (i) **EFFECTIVE DATE.**—The amendments made by  
21          this section shall apply to referrals made on or after Janu-  
22          ary 1, 1995, except that the amendments made by sub-  
23          section (h) shall apply as if included in the enactment of  
24          the Omnibus Budget Reconciliation Act of 1993.

1 **SEC. 6616. MEDICARE HEALTH MAINTENANCE ORGANIZA-**  
2 **TIONS.**

3 (a) STUDY ON COSTS OF PEER REVIEW CONTRACTS  
4 FOR MEDICARE HMO'S.—The Comptroller General shall  
5 conduct a study of the costs incurred by eligible organiza-  
6 tions with risk-sharing contracts under section 1876(b) of  
7 the Social Security Act of complying with the requirement  
8 of entering into a written agreement with an entity provid-  
9 ing peer review services with respect to services provided  
10 by the organization, together with an analysis of how in-  
11 formation generated by such entities is used by the Sec-  
12 retary of Health and Human Services to assess the quality  
13 of services provided by such eligible organizations.

14 (b) REPORT TO CONGRESS.—Not later than July 1,  
15 1997, the Comptroller General shall submit a report to  
16 the Committee on Ways and Means and the Committee  
17 on Energy and Commerce of the House of Representatives  
18 and the Committee on Finance and the Special Committee  
19 on Aging of the Senate on the study conducted under sub-  
20 section (a).

21 **SEC. 6617. EFFECTIVE DATE.**

22 Except as otherwise provided, the amendments made  
23 by this part shall take effect January 1, 1996.

24 **PART 3—AMENDMENTS TO CRIMINAL LAW**

25 **SEC. 6621. PENALTIES FOR HEALTH CARE FRAUD.**

26 (a) IN GENERAL.—

1           (1) FINES AND IMPRISONMENT FOR HEALTH  
2       CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,  
3       United States Code, is amended by adding at the  
4       end the following:

5   **“§ 1347. Health care fraud**

6       “(a) Whoever knowingly executes, or attempts to exe-  
7       cute, a scheme or artifice—

8           “(1) to defraud any health care plan or other  
9       person, in connection with the delivery of or pay-  
10      ment for health care benefits, items, or services; or

11          “(2) to obtain, by means of false or fraudulent  
12      pretenses, representations, or promises, any of the  
13      money or property owned by, or under the custody  
14      or control of, any health care plan, or person in con-  
15      nection with the delivery of or payment for health  
16      care benefits, items, or services;

17      shall be guilty of a felony, and fined under this title or  
18      imprisoned not more than 5 years, or both.

19      “(b) In determining the amount or scope of any pen-  
20      alty or assessment, the court shall take into account—

21          “(1) the nature of the false or fraudulent  
22      claims and the circumstances under which they are  
23      presented;

24          “(2) the degree of culpability and history of  
25      prior offenses by the convicted health care provider;

1 “(3) the extent to which restitution is paid; and

2 “(4) such other matters as justice may require.

3 “(c) A principal is liable for penalties and assess-  
4 ments under this section for the acts of the principal’s  
5 agents acting within the scope of the agency.

6 “(d) For purposes of this section, the term ‘health  
7 care plan’ means a Federally-funded public program or  
8 private program for the delivery of or payment for health  
9 care items or services.”.

10 (2) CLERICAL AMENDMENT.—The table of sec-  
11 tions at the beginning of chapter 63 of title 18,  
12 United States Code, is amended by adding at the  
13 end the following:

“1347. Health care fraud.”.

14 **SEC. 6622. REWARDS FOR INFORMATION LEADING TO**  
15 **PROSECUTION AND CONVICTION.**

16 Section 3059 of title 18, United States Code, is  
17 amended by adding at the end the following new sub-  
18 section:

19 “(c)(1) In special circumstances and in the Attorney  
20 General’s sole discretion, the Attorney General may make  
21 a payment of up to \$10,000 to a person who furnishes  
22 information unknown to the Government relating to a pos-  
23 sible prosecution under section 1347.

24 “(2) A person is not eligible for a payment under  
25 paragraph (1) if—



1           “(A) the person is a current or former officer  
2           or employee of a Federal or State government agen-  
3           cy or instrumentality who furnishes information dis-  
4           covered or gathered in the course of government em-  
5           ployment;

6           “(B) the person knowingly participated in the  
7           offense;

8           “(C) the information furnished by the person  
9           consists of allegations or transactions that have been  
10          disclosed to the public—

11               “(i) in a criminal, civil, or administrative  
12               proceeding;

13               “(ii) in a congressional, administrative or  
14               General Accounting Office report, hearing,  
15               audit or investigation; or

16               “(iii) by the news media, unless the person  
17               is the original source of the information; or

18           “(D) when, in the judgment of the Attorney  
19           General, it appears that a person whose illegal ac-  
20           tivities are being prosecuted or investigated could  
21           benefit from the award.

22          “(3) For the purposes of paragraph (2)(C)(iii), the  
23          term ‘original source’ means a person who has direct and  
24          independent knowledge of the information that is fur-

1 nished and has voluntarily provided the information to the  
2 Government prior to disclosure by the news media.

3 “(4) Neither the failure of the Attorney General to  
4 authorize a payment under paragraph (1) nor the amount  
5 authorized shall be subject to judicial review.”.

6 **SEC. 6623. BROADENING APPLICATION OF MAIL FRAUD**  
7 **STATUTE.**

8 Section 1341 of title 18, United States Code, is  
9 amended—

10 (1) by inserting “or deposits or causes to be de-  
11 posited any matter or thing whatever to be sent or  
12 delivered by any private or commercial interstate  
13 carrier,” after “Postal Service,”; and

14 (2) by inserting “or such carrier” after “causes  
15 to be delivered by mail”.

16 **PART 4—ADVISORY OPINIONS**

17 **SEC. 6631. AUTHORIZING THE SECRETARY OF HEALTH AND**  
18 **HUMAN SERVICES TO ISSUE ADVISORY OPIN-**  
19 **IONS UNDER TITLE XI.**

20 Title XI of the Social Security Act (42 U.S.C. 1301  
21 et seq.) is amended by inserting after section 1128B the  
22 following new section:

23 “ADVISORY OPINIONS

24 “SEC. 1129. (a) ISSUANCE OF ADVISORY OPIN-  
25 IONS.—The Secretary shall issue advisory opinions as pro-  
26 vided in this section.

1 “(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—

2 The Secretary shall issue advisory opinions as to the fol-

3 lowing matters:

4 “(1) What constitutes prohibited remuneration  
5 within the meaning of section 1128B(b).

6 “(2) Whether an arrangement or proposed ar-  
7 rangement satisfies the criteria set forth in section  
8 1128B(b)(3) for activities which do not result in  
9 prohibited remuneration.

10 “(3) Whether an arrangement or proposed ar-  
11 rangement satisfies the criteria which the Secretary  
12 has established, or shall establish by regulation for  
13 activities which do not result in prohibited remu-  
14 nation.

15 “(4) What constitutes an inducement to reduce  
16 or limit services to individuals entitled to benefits  
17 under title XVIII or title XIX within the meaning  
18 of section 1128B(b).

19 “(5) Whether an arrangement, activity or pro-  
20 posed arrangement or proposed activity violates any  
21 other provision of this Act.

22 “(c) MATTERS NOT SUBJECT TO ADVISORY OPIN-  
23 IONS.—Such advisory opinions shall not address the fol-  
24 lowing matters:

1           “(1) Whether the fair market value shall be, or  
2           was paid or received for any goods, services or prop-  
3           erty.

4           “(2) Whether an individual is a bona fide em-  
5           ployee within the requirements of section 3121(d)(2)  
6           of the Internal Revenue Code of 1986.

7           “(d) EFFECT OF ADVISORY OPINIONS.—

8           “(1) Each advisory opinion issued by the Sec-  
9           retary shall be binding as to the Secretary and the  
10          party or parties requesting the opinion.

11          “(2) The failure of a party to seek an advisory  
12          opinion may not be introduced into evidence to prove  
13          that the party intended to violate the provisions of  
14          sections 1128, 1128A, or 1128B.

15          “(e) REGULATIONS.—The Secretary within 180 days  
16          of the date of enactment, shall issue regulations establish-  
17          ing a system for the issuance of advisory opinions. Such  
18          regulations shall provide for—

19               “(1) the procedure to be followed by a party ap-  
20               plying for an advisory opinion;

21               “(2) the procedure to be followed by the Sec-  
22               retary in responding to a request for an advisory  
23               opinion;

24               “(3) the interval in which the Secretary shall  
25               respond;

1           “(4) the reasonable fee to be charged to the  
2           party requesting an advisory opinion; and

3           “(5) the manner in which advisory opinions will  
4           be made available to the public.

5           “(f) INTERVAL FOR ISSUANCE OF ADVISORY OPIN-  
6           IONS.—Under no circumstances shall the interval in which  
7           the Secretary shall respond to a party requesting an advisory  
8           opinion exceed 30 days.”.

9   **SEC. 6632. AUTHORIZING THE SECRETARY OF HEALTH AND**  
10                   **HUMAN SERVICES TO ISSUE ADVISORY OPIN-**  
11                   **IONS RELATING TO PHYSICIAN OWNERSHIP**  
12                   **AND REFERRAL.**

13           Section 1877 of the Social Security Act (42 U.S.C.  
14   1395nn) is amended by the addition of the following new  
15   subsection:

16           “(i) ADVISORY OPINIONS.—

17                   “(1) IN GENERAL.—The Secretary shall issue  
18           advisory opinions on whether an arrangement or  
19           proposed arrangement will result in a prohibited re-  
20           ferral within the meaning of this section.

21                   “(2) EFFECT OF ADVISORY OPINIONS.—

22                           “(A) Each advisory opinion issued by the  
23           Secretary shall be binding as to the Secretary  
24           and the party or parties requesting the opinion.

1           “(B) The failure of a party to seek an ad-  
2           visory opinion may not be introduced into evi-  
3           dence to prove that the party intended to vio-  
4           late the provisions of this section.

5           “(3) REGULATIONS.—The Secretary within one  
6           hundred and eighty days of the date of enactment,  
7           shall issue regulations establishing a system for the  
8           issuance of advisory opinions. Such regulations shall  
9           provide for—

10           “(A) the procedure to be followed by a  
11           party applying for an advisory opinion;

12           “(B) the procedure to be followed by the  
13           Secretary in responding to a request for an ad-  
14           visory opinion;

15           “(C) the interval in which the Secretary  
16           shall respond;

17           “(D) the reasonable fee to be charged to  
18           the party requesting an advisory opinion; and

19           “(E) the manner in which advisory opin-  
20           ions will be made available to the public.

21           “(4) INTERVAL FOR ISSUANCE OF ADVISORY  
22           OPINIONS.—Under no circumstances shall the inter-  
23           val in which the Secretary shall respond to a party  
24           requesting an advisory opinion exceed thirty days.”.

1 **SEC. 6633. EFFECTIVE DATE.**

2 Unless otherwise specified, the amendments made by  
3 this part shall be effective upon the enactment of this Act.

4 **PART 5—PAYMENTS FOR STATE HEALTH CARE**

5 **FRAUD CONTROL UNITS**

6 **SEC. 6641. ESTABLISHMENT OF STATE FRAUD UNITS.**

7 (a) ESTABLISHMENT OF HEALTH CARE FRAUD AND  
8 ABUSE CONTROL UNIT.—Each State shall, consistent  
9 with State law, establish and maintain in accordance with  
10 subsection (b) a State agency to act as a Health Care  
11 Fraud and Abuse Control Unit for purposes of this part.

12 (b) DEFINITION.—In this section, a “State Fraud  
13 Unit” means a Health Care Fraud and Abuse Control  
14 Unit designated under subsection (a) that the Attorney  
15 General certifies meets the requirements of this part.

16 **SEC. 6642. REQUIREMENTS FOR STATE FRAUD UNITS.**

17 (a) IN GENERAL.—The State Fraud Unit must—

18 (1) be a single identifiable entity of the State  
19 government;

20 (2) be separate and distinct from any State  
21 agency with principal responsibility for the adminis-  
22 tration of any Federally-funded or mandated health  
23 care program; and

24 (3) meet the other requirements of this section.

25 (b) SPECIFIC REQUIREMENTS DESCRIBED.—The  
26 State Fraud Unit shall—

1           (1) be a Unit of the office of the State Attorney  
2       General or of another department of State govern-  
3       ment which possesses statewide authority to pros-  
4       ecute individuals for criminal violations;

5           (2) if it is in a State the constitution of which  
6       does not provide for the criminal prosecution of indi-  
7       viduals by a statewide authority and has formal pro-  
8       cedures, (A) assure its referral of suspected criminal  
9       violations to the appropriate authority or authorities  
10      in the State for prosecution, and (B) assure its as-  
11      sistance of, and coordination with, such authority or  
12      authorities in such prosecutions; or

13          (3) have a formal working relationship with the  
14      office of the State Attorney General or the appro-  
15      priate authority or authorities for prosecution and  
16      have formal procedures (including procedures for its  
17      referral of suspected criminal violations to such of-  
18      fice) which provide effective coordination of activities  
19      between the Fraud Unit and such office with respect  
20      to the detection, investigation, and prosecution of  
21      suspected criminal violations relating to any Feder-  
22      ally-funded or mandated health care programs.

23      (c) STAFFING REQUIREMENTS.—The Fraud Unit  
24      must—



1           (1) employ attorneys, auditors, investigators  
2           and other necessary personnel; and

3           (2) be organized in such a manner and provide  
4           sufficient resources as is necessary to promote the  
5           effective and efficient conduct of Fraud Unit activi-  
6           ties.

7           (d) COOPERATIVE AGREEMENTS; MEMORANDA OF  
8           UNDERSTANDING.—The Fraud Unit must have coopera-  
9           tive agreements with—

10           (1) Federally-funded or mandated health care  
11           programs;

12           (2) similar Fraud Units in other States, as ex-  
13           emplified through membership and participation in  
14           the National Association of Medicaid Fraud Control  
15           Units or its successor; and

16           (3) the Attorney General of the United States  
17           and the Inspector General of the Department of  
18           Health and Human Services.

19           (e) REPORTS.—The Fraud Unit shall submit to the  
20           Attorney General an application and an annual report con-  
21           taining such information as the Attorney General deter-  
22           mines to be necessary to determine whether the Fraud  
23           Unit meets the requirements of this section.

24           (f) FUNDING SOURCE; PARTICIPATION IN ALL-  
25           PAYER PROGRAM.—The Fraud Unit may receive funding

1 for its activities from such sources as the State considers  
2 appropriate. The Fraud Unit shall participate in the all-  
3 payer fraud and abuse control program established under  
4 section 6601.

5 (g) USE OF MEDICAID FRAUD CONTROL UNITS.—  
6 If a State has a medicaid fraud control unit under title  
7 XIX of the Social Security Act in operation as of the date  
8 of the enactment of this Act, such unit shall be deemed  
9 to meet the requirements of this part and to serve as the  
10 State Fraud Unit under this part if the State dem-  
11 onstrates that the Unit will be able to carry out the activi-  
12 ties described in section 6643.

13 **SEC. 6643. SCOPE AND PURPOSE.**

14 The Fraud Unit shall carry out the following activi-  
15 ties:

16 (1) The Fraud Unit shall conduct a statewide  
17 program for the investigation and prosecution (or re-  
18 ferring for prosecution) of violations of all applicable  
19 state laws regarding any and all aspects of fraud in  
20 connection with any aspect of the administration  
21 and provision of health care services and activities of  
22 providers of such services under any Federally-fund-  
23 ed or mandated health care programs.

24 (2) The Fraud Unit shall have procedures for  
25 reviewing complaints of the abuse or neglect of pa-

1       tients of facilities (including patients in residential  
2       facilities and home health care programs) that re-  
3       ceive payments under any Federally-funded or man-  
4       dated health care programs, and, where appropriate,  
5       to investigate and prosecute such complaints under  
6       the criminal laws of the State or for referring the  
7       complaints to other State agencies for action.

8           (3) The Fraud Unit shall provide for the collec-  
9       tion, or referral for collection to the appropriate  
10      agency, of overpayments that are made under any  
11      Federally-funded or mandated health care program  
12      and that are discovered by the Fraud Unit in carry-  
13      ing out its activities.

14   **SEC. 6644. PAYMENTS TO STATES.**

15      (a) IN GENERAL.—

16           (1) MATCHING PAYMENTS TO STATES.—Subject  
17      to subsection (c), for each year for which a State  
18      has a Fraud Unit approved under section 6642(b) in  
19      operation the Attorney General shall pay to the  
20      State for each quarter in a fiscal year an amount  
21      equal to the applicable percentage of the sums ex-  
22      pended during the quarter by the Fraud Unit.

23           (2) TIME OF PAYMENT.—The Attorney General  
24      shall make a payment under paragraph (1) for a

1 quarter by not later than 30 days after the end of  
2 the quarter.

3 (b) APPLICABLE PERCENTAGE DEFINED.—

4 (1) IN GENERAL.—In subsection (a), the “ap-  
5 plicable percentage” with respect to a State for a  
6 fiscal year is—

7 (A) 90 percent, for quarters occurring dur-  
8 ing the first 3 years for which the Fraud Unit  
9 is in operation; or

10 (B) 75 percent, for any other quarters.

11 (2) TREATMENT OF STATES WITH MEDICAID  
12 FRAUD CONTROL UNITS.—In the case of a State  
13 with a State medicaid fraud control unit in oper-  
14 ation prior to or as of the date of the enactment of  
15 this Act, in determining the number of years for  
16 which the State’s Fraud Unit under this part has  
17 been in operation, there shall be included the num-  
18 ber of years for which such State medicaid fraud  
19 control unit was in operation.

20 (c) LIMIT ON PAYMENT.—Notwithstanding sub-  
21 section (a), the total amount of payments made to a State  
22 under this section for a fiscal year may not exceed—

23 (1) for fiscal year 1996, 4 times the amount  
24 paid to the State under section 1903(a)(6) of the

1 Social Security Act during the first quarter of 1995;  
2 and

3 (2) for each succeeding fiscal year, the amount  
4 determined under this subsection in the previous fis-  
5 cal year, increased by the percentage increase in the  
6 consumer price index for all urban consumers (U.S.  
7 city average) for the year.

8 **Subtitle H—Billing for Laboratory**  
9 **Services**

10 **SEC. 6701. EASING RESTRICTIONS ON BILLING FOR LAB-**  
11 **ORATORY AND OTHER SERVICES.**

12 (a) IN GENERAL.—The Public Health Service Act is  
13 amended—

14 (1) by redesignating title XXVII (42 U.S.C.  
15 300cc et seq.) as title XXVIII; and

16 (2) by inserting after title XXVI the following  
17 new title:

18 **“TITLE XXVII—RESTRICTIONS**  
19 **ON BILLING**

20 **“SEC. 2701. PROHIBITION.**

21 “(a) BILLING OF OTHERS FOR ANCILLARY HEALTH  
22 SERVICES.—Except as provided in section 2702, it shall  
23 be unlawful for any person (including any individual or  
24 entity) who furnishes ancillary health services (as defined  
25 in section 2705(1)) to present or cause to be presented,

1 a claim, bill, or demand for payment to any person other  
2 than the patient receiving such services.

3 “(b) BILLING OF RECIPIENT OF SERVICES.—Except  
4 as provided in section 2702, it shall be unlawful for any  
5 physician, or the agent of any physician, to present, or  
6 cause to be presented, a claim, bill, or demand for pay-  
7 ment for ancillary health services to any recipient of such  
8 services unless the services covered by the claim, bill, or  
9 demand were furnished—

10 “(1) personally by, or under the supervision of,  
11 the referring physician;

12 “(2) personally by, or under the supervision of,  
13 a physician who is a member of the same group  
14 practice as the referring physician; or

15 “(3) personally by individuals who are employed  
16 by such physician or group practice and who are  
17 personally supervised by the physician or by another  
18 physician in the group practice.

19 “(c) GENERAL EXCEPTION FOR SERVICES UNDER  
20 MEDICARE.—This section does not apply with respect to  
21 any ancillary health services for which payment may be  
22 made under title XVIII of the Social Security Act.

23 **“SEC. 2702. EXCEPTIONS.**

24 “Notwithstanding the provisions of section 2701, a  
25 person who furnishes ancillary health services to an indi-

1   vidual may present, or cause to be presented, for payment  
2   for actual services rendered a claim, bill, or demand to—

3           “(1) an immediate family member of the recipi-  
4       ent of the services or any other person legally re-  
5       sponsible for the debts or care of the recipient of the  
6       services;

7           “(2) a third party payer designated by the re-  
8       cipient of the services;

9           “(3) a health maintenance organization, or  
10      other health plan providing coverage through a man-  
11      aged care arrangement, in which the recipient of the  
12      services is enrolled;

13          “(4) a hospital or skilled nursing facility where  
14      the recipient of the services was an inpatient or out-  
15      patient at the time the services were provided;

16          “(5) an employer where the recipient of the  
17      services is an employee of such employer and the  
18      employer is responsible for payment for the services;

19          “(6) a governmental agency or specified agent,  
20      on behalf of the recipient of the services;

21          “(7) a substance abuse program where the cli-  
22      ents of such a program were the recipient of the  
23      services;

24          “(8) a clinic or other health care provider that  
25      has been designated (or that is operated by an orga-

1 nization that has been designated) as tax-exempt  
2 pursuant to section 501(c)(3) of the Internal Reve-  
3 nue Code of 1986 whose purpose is the promotion  
4 of public health, if the services rendered relate to  
5 testing for sexually transmitted disease, acquired im-  
6 mune deficiency syndrome, pregnancy, pregnancy  
7 termination, or other conditions where the Secretary  
8 has determined that compliance with section 2701  
9 could seriously compromise the recipient's need for  
10 confidentiality;

11 “(9) a person engaged in bona fide research  
12 studies;

13 “(10) the party requesting the ancillary health  
14 services where Federal, State, or local law requires  
15 that the identity of the recipient be kept confiden-  
16 tial;

17 “(11) another person furnishing the same ancil-  
18 lary health services for which payment is sought  
19 (hereafter referred to in this paragraph as the ‘re-  
20 questing party’) where the person presenting, or  
21 causing to be presented, the claim, bill, or demand  
22 for payment furnished the services at the request of  
23 the requesting party, except that the requesting  
24 party may not be a facility owned or operated by the  
25 physician requesting the ancillary health service; and



1           “(12) an entity approved to receive such claims,  
2       bills or demands by the Secretary in regulations.

3       The persons described in paragraphs (1) through (12) who  
4       have received a claim, bill, or demand for payment for  
5       such ancillary health services may present, or cause to be  
6       presented, such claim, bill, or demand to the responsible  
7       party.

8       **“SEC. 2703. SANCTIONS.**

9           “(a) PAYMENT.—No payment may be made for a  
10      service that is provided in violation of section 2701.

11          “(b) COLLECTION OF AMOUNTS.—

12           “(1) LIABILITY ON COLLECTION.—If a person  
13      collects any amounts that were billed in violation of  
14      section 2701(a), such person shall be liable for, and  
15      shall refund on a timely basis to the individual  
16      whom such amounts were collected, any amounts so  
17      collected.

18           “(2) COLLECTION BY PHYSICIAN.—If a physi-  
19      cian collects any amounts from a recipient of serv-  
20      ices, or from another person on behalf of the recipi-  
21      ent of services (including a third-party payer) that  
22      were billed in violation of section 2701(b), such phy-  
23      sician shall be liable for, and shall refund on a time-  
24      ly basis to the recipient or person, any amounts so  
25      collected.

1       “(c) REPEATED CLAIMS.—Any person that presents,  
2 or causes to be presented, on a repeated basis, a bill or  
3 a claim that such person knows, or should have known,  
4 is for a service for which payment may not be made under  
5 subsection (a), or for which a refund has not been made  
6 under subsection (b), shall be subject to a civil money pen-  
7 alty of not more than \$5,000 for each such bill or claim.  
8 The provisions of section 1128A of the Social Security Act  
9 (other than the first sentence of subsection (a) and sub-  
10 section (b)) shall apply to a civil money penalty assessed  
11 under the previous sentence in the same manner as such  
12 provisions apply to a penalty or proceeding under such  
13 section 1128A(a).

14       “(d) SUSPENSION OF LABORATORY CERTIFI-  
15 CATION.—If the Secretary finds, after reasonable notice  
16 and opportunity for a hearing, that a laboratory which  
17 holds a certificate pursuant to section 353 has violated  
18 section 2701, the Secretary may suspend, revoke or limit  
19 such certification in accordance with the procedures estab-  
20 lished in section 353(k).

21       “(e) EXCLUSION FROM OTHER PROGRAMS.—

22               “(1) AUTHORITY.—The Secretary may exclude  
23 from participation in any program under title XVIII  
24 of the Social Security Act, any individual or entity  
25 that the Secretary determines has violated section

1       2701 and may direct that such individual and entity  
2       be excluded from participation in any State health  
3       care program receiving Federal funds.

4           “(2) APPLICATION OF OTHER LAW.—The provi-  
5       sions of section 1128(e) of the Social Security Act  
6       shall apply to any exclusion under paragraph (1) in  
7       the same manner as such provisions apply to a pro-  
8       ceeding under such section 1128.

9       **“SEC. 2704. REGULATIONS.**

10       “The Secretary shall by regulation impose such other  
11       requirements as may be necessary to implement the pur-  
12       poses of this title.

13       **“SEC. 2705. DEFINITIONS.**

14       “As used in this title:

15           “(1) ANCILLARY HEALTH SERVICES.—The term  
16       ‘ancillary health services’ means—

17               “(A) clinical laboratory services;

18               “(B) diagnostic x-ray tests and other diag-  
19       nostic imaging services including CT and mag-  
20       netic resonance imaging services;

21               “(C) other diagnostic tests;

22               “(D) durable medical equipment; and

23               “(E) physical therapy services.

24           “(2) GROUP PRACTICES.—The term ‘group  
25       practice’ means a group of 2 or more physicians le-

1 gally organized as a partnership, professional cor-  
2 poration, foundation, not-for-profit corporation, fac-  
3 ulty practice plan, or similar association—

4 “(A) in which each physician who is a  
5 member of the group provides substantially the  
6 full range of services that the physician rou-  
7 tinely provides (including medical care, con-  
8 sultation, diagnosis, or treatment) through the  
9 joint use of shared office space, facilities, equip-  
10 ment, and personnel;

11 “(B) for which substantially all of the serv-  
12 ices of the physicians who are members of the  
13 group are provided through the group and are  
14 billed in the name of the group and amounts so  
15 received are treated as receipts of the group;

16 “(C) in which the overhead expenses of  
17 and the income from the practice are distrib-  
18 uted in accordance with methods previously de-  
19 termined by members of the group; and

20 “(D) which meets such other standards as  
21 the Secretary may impose by regulation.

22 In the case of a faculty practice plan associated with  
23 a hospital with an approved medical residency train-  
24 ing program in which physician members may pro-  
25 vide a variety of different specialty services and pro-

1       vide professional services both within and outside the  
2       group (as well as perform other tasks, such as re-  
3       search), the definition of such term shall be limited  
4       with respect to the services provided outside of the  
5       faculty practice plan.

6               “(3) IMMEDIATE FAMILY MEMBER.—The term  
7       ‘immediate family member’ shall include spouses,  
8       natural and adoptive parents, natural and adoptive  
9       children, natural and adopted siblings, stepparents,  
10      stepchildren and stepsiblings, fathers-in-law, moth-  
11      ers-in-law, brothers-in-law, sisters-in-law, sons-in-law  
12      and daughters-in-law, grandparents and grand-  
13      children, and such additional family members as  
14      may be specified in regulations adopted by the Sec-  
15      retary.

16              “(4) PHYSICIAN.—The term ‘physician’  
17      means—

18                      “(A) a doctor of medicine or osteopathy le-  
19                      gally authorized to practice medicine and per-  
20                      form surgery by the State in which such indi-  
21                      vidual performs such function or action;

22                      “(B) a doctor of dental surgery or of den-  
23                      tal medicine who is legally authorized to prac-  
24                      tice dentistry in the State in which such indi-  
25                      vidual performs such functions;

1 “(C) a doctor of podiatric medicine;

2 “(D) a doctor of optometry; or

3 “(E) a chiropractor.

4 “(5) THIRD PARTY PAYER.—The term ‘third  
5 party payer’ means any health care insurer, includ-  
6 ing any hospital services corporation, health services  
7 corporation, medical expense indemnity corporation,  
8 mutual insurance company, or self-insured corpora-  
9 tion, that provides coverage for health or health-re-  
10 lated items or service.”.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Sections 2701 through 2714 of the Public  
13 Health Service Act (42 U.S.C. 300cc through  
14 300cc–15) are redesignated as sections 2801  
15 through 2814, respectively.

16 (2)(A) Sections 465(f) and 497 of such Act (42  
17 U.S.C. 286(f) and 289) are amended by striking out  
18 “2701” each place that such appears and inserting  
19 in lieu thereof “2801”.

20 (B) Section 305(i) of such Act (42 U.S.C.  
21 242c(i)) is amended by striking out “2711” each  
22 place that such appears and inserting in lieu thereof  
23 “2811”.

1 **SEC. 6702. EFFECTIVE DATE.**

2 (a) IN GENERAL.—Title XXVII of the Public Health  
3 Service Act, as added by section 6701(a), shall become ef-  
4 fective December 31, 1994.

5 (b) REGULATIONS.—Not later than July 1, 1995, the  
6 Secretary of Health and Human Services shall promulgate  
7 such regulations as may be appropriate to carry out such  
8 title.

9 **TITLE VII—MEDICARE**

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## 1     **Subtitle A—Increased Beneficiary** 2             **Choice; Improved Program** 3                     **Efficiency**

### 4             **PART 1—INCREASED BENEFICIARY CHOICE**

#### 5     **SEC. 7001. REQUIREMENTS FOR HEALTH MAINTENANCE**

##### 6                     **ORGANIZATIONS UNDER MEDICARE.**

7             (a) USE OF METROPOLITAN STATISTICAL AREAS TO  
8 DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—  
9 Section 1876(a)(4) of the Social Security Act (42 U.S.C.  
10 1395mm(a)(4)) is amended by striking “in a geographic  
11 area served by an eligible organization or in a similar  
12 area” and inserting “in the metropolitan statistical area  
13 (as defined by the Office of Management and Budget) in  
14 which the individual resides, or in the entire portion of  
15 the State in which the individual resides which is not lo-  
16 cated in a metropolitan statistical area in the case of an  
17 individual who does not reside in a metropolitan statistical  
18 area”.



1 (b) DETERMINATION OF MODEL ADDITIONAL  
2 HEALTH BENEFIT PACKAGES.—Section 1876(g) of such  
3 Act (42 U.S.C. 1395mm(g)) is amended by inserting after  
4 paragraph (3) the following new paragraph:

5 “(4) The Secretary shall develop the following model  
6 packages of additional health benefits (referred to in para-  
7 graph (3)(B)) which an eligible organization may provide  
8 (at its option) under paragraph (2):

9 “(A) Coverage for catastrophic illness (subject  
10 to a limit on out-of-pocket expenditures).

11 “(B) Coverage for prescription drugs.

12 “(C) Coverage for preventive services.”.

13 (c) REVISION OF MEMBERSHIP LIMITATION.—Sec-  
14 tion 1876(f) of such Act (42 U.S.C. 1395mm(f)) is  
15 amended—

16 (1) in paragraph (1), by striking “one-half”  
17 and inserting “25 percent”; and

18 (2) in paragraph (2)(A), by striking “50 per-  
19 cent” and inserting “75 percent”.

20 (d) ENROLLMENT PERIODS FOR MEDICARE HEALTH  
21 MAINTENANCE ORGANIZATIONS.—

22 (1) UNIFORM OPEN ENROLLMENT PERIOD.—  
23 Section 1876(c)(3)(A)(i) of such Act (42 U.S.C.  
24 1395mm(c)(3)(A)(i)) is amended by striking “must  
25 have” and all that follows through “and including”

1 and inserting the following: “shall have open enroll-  
2 ment during an annual uniform open enrollment pe-  
3 riod established by the Secretary for all eligible orga-  
4 nizations, together with”.

5 (2) OPEN ENROLLMENT FOR CERTAIN  
6 DISENROLLED INDIVIDUALS.—Section  
7 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C.  
8 1395mm(c)(3)(A)(ii)(I)) is amended by adding at  
9 the end the following: “Each eligible organization  
10 with a risk-sharing contract under this section shall  
11 have an open enrollment period for individuals resid-  
12 ing in the organization’s service area who disenroll  
13 from another eligible organization with a risk-shar-  
14 ing contract under this section on the grounds that  
15 the individual’s primary care physician is no longer  
16 a member of the organization’s provider network or  
17 for cause (in accordance with such standards, and as  
18 demonstrated through an appeals process that meets  
19 such requirements, as the Secretary may establish).  
20 (e) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply to contracts entered into on or  
22 after the date of the enactment of this Act.

1 **SEC. 7002. EXPANSION AND REVISION OF MEDICARE SE-**  
2 **LECT POLICIES.**

3 (a) PERMITTING MEDICARE SELECT POLICIES IN  
4 ALL STATES.—

5 (1) IN GENERAL.—Subsection (c) of section  
6 4358 of the Omnibus Budget Reconciliation Act of  
7 1990 (hereafter referred to as “OBRA–1990”) is  
8 hereby repealed.

9 (2) CONFORMING AMENDMENT.—Section 4358  
10 of OBRA–1990 is amended by redesignating sub-  
11 section (d) as subsection (c).

12 (b) REQUIREMENTS OF MEDICARE SELECT POLI-  
13 CIES.—Section 1882(t)(1) of the Social Security Act (42  
14 U.S.C. 1395ss(t)(1)) is amended to read as follows:

15 “(1)(A) If a medicare supplemental policy meets the  
16 1991 NAIC Model Regulation or 1991 Federal Regulation  
17 and otherwise complies with the requirements of this sec-  
18 tion except that—

19 “(i) the benefits under such policy are re-  
20 stricted to items and services furnished by certain  
21 entities (or reduced benefits are provided when items  
22 or services are furnished by other entities), and

23 “(ii) in the case of a policy described in sub-  
24 paragraph (C)(i)—

1           “(I) the benefits under such policy are not  
2           one of the groups or packages of benefits de-  
3           scribed in subsection (p)(2)(A),

4           “(II) except for nominal copayments im-  
5           posed for services covered under part B of this  
6           title, such benefits include at least the core  
7           group of basic benefits described in subsection  
8           (p)(2)(B), and

9           “(III) an enrollee’s liability under such pol-  
10          icy for physician’s services covered under part  
11          B of this title is limited to the nominal  
12          copayments described in subclause (II),

13          the policy shall nevertheless be treated as meeting those  
14          standards if the policy meets the requirements of subpara-  
15          graph (B).

16          “(B) A policy meets the requirements of this sub-  
17          paragraph if—

18               “(i) full benefits are provided for items and  
19               services furnished through a network of entities  
20               which have entered into contracts or agreements  
21               with the issuer of the policy,

22               “(ii) full benefits are provided for items and  
23               services furnished by other entities if the services are  
24               medically necessary and immediately required be-  
25               cause of an unforeseen illness, injury, or condition

1       and it is not reasonable given the circumstances to  
2       obtain the services through the network,

3               “(iii) the network offers sufficient access,

4               “(iv) the issuer of the policy has arrangements  
5       for an ongoing quality assurance program for items  
6       and services furnished through the network,

7               “(v)(I) the issuer of the policy provides to each  
8       enrollee at the time of enrollment an explanation  
9       of—

10               “(aa) the restrictions on payment under  
11       the policy for services furnished other than by  
12       or through the network,

13               “(bb) out of area coverage under the pol-  
14       icy,

15               “(cc) the policy’s coverage of emergency  
16       services and urgently needed care, and

17               “(dd) the availability of a policy through  
18       the entity that meets the 1991 Model NAIC  
19       Regulation or 1991 Federal Regulation without  
20       regard to this subsection and the premium  
21       charged for such policy, and

22               “(II) each enrollee prior to enrollment acknowl-  
23       edges receipt of the explanation provided under  
24       subclause (I), and

1           “(vi) the issuer of the policy makes available to  
2 individuals, in addition to the policy described in this  
3 subsection, any policy (otherwise offered by the is-  
4 suer to individuals in the State) that meets the 1991  
5 Model NAIC Regulation or 1991 Federal Regulation  
6 and other requirements of this section without re-  
7 gard to this subsection.

8           “(C) (i) A policy described in this subparagraph—

9           “(I) is offered by an eligible organization (as  
10 defined in section 1876(b)),

11           “(II) is not a policy or plan providing benefits  
12 pursuant to a contract under section 1876 or an ap-  
13 proved demonstration project described in section  
14 603(c) of the Social Security Amendments of 1983,  
15 section 2355 of the Deficit Reduction Act of 1984,  
16 or section 9412(b) of the Omnibus Budget Reconcili-  
17 ation Act of 1986, and

18           “(III) provides benefits which, when combined  
19 with benefits which are available under this title, are  
20 substantially similar to benefits under policies of-  
21 fered to individuals who are not entitled to benefits  
22 under this title.

23           “(ii) In making a determination under subclause (III)  
24 of clause (i) as to whether certain benefits are substan-  
25 tially similar, there shall not be taken into account, except

1 in the case of preventive services, benefits provided under  
2 policies offered to individuals who are not entitled to bene-  
3 fits under this title which are in addition to the benefits  
4 covered by this title and which are benefits an entity must  
5 provide in order to meet the definition of an eligible orga-  
6 nization under section 1876(b)(1).’.

7 (c) RENEWABILITY OF MEDICARE SELECT POLI-  
8 CIES.—Section 1882(q)(1) of the Social Security Act (42  
9 U.S.C. 1395ss(q)(1)) is amended—

10 (1) by striking “(1) Each” and inserting  
11 “(1)(A) Except as provided in subparagraph (B),  
12 each”;

13 (2) by redesignating subparagraphs (A) and  
14 (B) as clauses (i) and (ii), respectively; and

15 (3) by adding at the end the following new sub-  
16 paragraph:

17 “(B)(i) Except as provided in clause (ii), in the  
18 case of a policy that meets the requirements of sub-  
19 section (t), an issuer may cancel or nonrenew such  
20 policy with respect to an individual who leaves the  
21 service area of such policy.

22 “(ii) If an individual described in clause (i)  
23 moves to a geographic area where an issuer de-  
24 scribed in clause (i), or where an affiliate of such is-  
25 suer, is issuing medicare supplemental policies, such

1 individual must be permitted to enroll in any medi-  
2 care supplemental policy offered by such issuer or  
3 affiliate that provides benefits comparable to or less  
4 than the benefits provided in the policy being can-  
5 celed or nonrenewed. An individual whose coverage  
6 is canceled or nonrenewed under this subparagraph  
7 shall, as part of the notice of termination or  
8 nonrenewal, be notified of the right to enroll in other  
9 medicare supplemental policies offered by the issuer  
10 or its affiliates.

11 “(iii) For purposes of this subparagraph, the  
12 term ‘affiliate’ shall have the meaning given such  
13 term by the 1991 NAIC Model Regulation.”.

14 (d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of  
15 the Social Security Act (42 U.S.C. 1395ss(t)(2)) is  
16 amended—

17 (1) by striking “(2)” and inserting “(2)(A)”;

18 (2) by redesignating subparagraphs (A), (B),  
19 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-  
20 spectively;

21 (3) in clause (iv), as so redesignated—

22 (A) by striking “paragraph (1)(E)(i)” and  
23 inserting “paragraph (1)(B)(v)(I), and

24 (B) by striking “paragraph (1)(E)(ii)” and  
25 inserting “paragraph (1)(B)(v)(II)”;



1           (4) by striking “the previous sentence” and in-  
2       serting “this subparagraph”; and

3           (5) by adding at the end the following new sub-  
4       paragraph:

5       “(B) If the Secretary determines that an issuer of  
6       a policy approved under paragraph (1) has made a mis-  
7       representation to the Secretary or has provided the Sec-  
8       retary with false information regarding such policy, the  
9       issuer is subject to a civil money penalty in an amount  
10      not to exceed \$100,000 for each such determination. The  
11      provisions of section 1128A (other than the first sentence  
12      of subsection (a) and other than subsection (b)) shall  
13      apply to a civil money penalty under this subparagraph  
14      in the same manner as such provisions apply to a penalty  
15      or proceeding under section 1128A(a).”.

16      (e) EFFECTIVE DATES.—

17           (1) NAIC STANDARDS.—If, within 6 months  
18      after the date of the enactment of this Act, the Na-  
19      tional Association of Insurance Commissioners  
20      (hereafter in this subsection referred to as the  
21      “NAIC”) makes changes in the 1991 NAIC Model  
22      Regulation (as defined in section 1882(p)(1)(A) of  
23      the Social Security Act) to incorporate the additional  
24      requirements imposed by the amendments made by  
25      this section, section 1882(g)(2)(A) of such Act shall

1 be applied in each State, effective for policies issued  
2 to policyholders on and after the date specified in  
3 paragraph (3), as if the reference to the Model Reg-  
4 ulation adopted on June 6, 1979, were a reference  
5 to the 1991 NAIC Model Regulation (as so defined)  
6 as changed under this paragraph (such changed  
7 Regulation referred to in this subsection as the  
8 “1994 NAIC Model Regulation”).

9 (2) SECRETARY STANDARDS.—If the NAIC  
10 does not make changes in the 1991 NAIC Model  
11 Regulation (as so defined) within the 6-month period  
12 specified in paragraph (1), the Secretary of Health  
13 and Human Services (in this subsection as the “Sec-  
14 retary”) shall promulgate a regulation and section  
15 1882(g)(2)(A) of the Social Security Act shall be ap-  
16 plied in each State, effective for policies issued to  
17 policyholders on and after the date specified in para-  
18 graph (3), as if the reference to the Model Regula-  
19 tion adopted in June 6, 1979, were a reference to  
20 the 1991 NAIC Model Regulation (as so defined) as  
21 changed by the Secretary under this paragraph  
22 (such changed Regulation referred to in this sub-  
23 section as the “1994 Federal Regulation”).

24 (3) DATE SPECIFIED.—

1 (A) IN GENERAL.—Subject to subpara-  
2 graph (B), the date specified in this paragraph  
3 for a State is the earlier of—

4 (i) the date the State adopts the 1994  
5 NAIC Model Regulation or the 1994 Fed-  
6 eral Regulation; or

7 (ii) 1 year after the date the NAIC or  
8 the Secretary first adopts such regulations.

9 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
10 QUIRED.—In the case of a State which the Sec-  
11 retary identifies, in consultation with the NAIC,  
12 as—

13 (i) requiring State legislation (other  
14 than legislation appropriating funds) in  
15 order for medicare supplemental policies to  
16 meet the 1994 NAIC Model Regulation or  
17 the 1994 Federal Regulation, but

18 (ii) having a legislature which is not  
19 scheduled to meet in 1995 in a legislative  
20 session in which such legislation may be  
21 considered,

22 the date specified in this paragraph is the first  
23 day of the first calendar quarter beginning after  
24 the close of the first legislative session of the  
25 State legislature that begins on or after Janu-

1           ary 1, 1995. For purposes of the previous sen-  
2           tence, in the case of a State that has a 2-year  
3           legislative session, each year of such session  
4           shall be deemed to be a separate regular session  
5           of the State legislature.

6   **SEC. 7003. INCLUDING NOTICE OF AVAILABLE HEALTH**  
7                   **MAINTENANCE ORGANIZATIONS IN ANNUAL**  
8                   **NOTICE TO BENEFICIARIES.**

9           Section 1804 of the Social Security Act (42 U.S.C.  
10 1395b-2) is amended—

11           (1) by striking “and” at the end of paragraph  
12           (2);

13           (2) by striking the period at the end of para-  
14           graph (3) and inserting “, and”; and

15           (3) by inserting after paragraph (3) the follow-  
16           ing new paragraph:

17           “(4) with respect to the area in which the indi-  
18           vidual receiving the notice resides, a description of  
19           the eligible organizations under section 1833(a)(1)  
20           or section 1876 and the carriers offering a medicare  
21           supplemental policy described in section 1882(t)(1)  
22           which serve the area in which the individual receiv-  
23           ing the notice resides.”.

1 **SEC. 7004. LEGISLATIVE PROPOSAL ON ENROLLING MEDI-**  
2 **CARE BENEFICIARIES IN QUALIFIED HEALTH**  
3 **PLANS.**

4 (a) IN GENERAL.—

5 (1) LEGISLATIVE PROPOSAL.—Not later than 1  
6 year after the date of the enactment of this Act, the  
7 Secretary shall develop and submit to Congress a  
8 proposal for legislation which provides for the vol-  
9 untary enrollment of medicare beneficiaries in pri-  
10 vate health insurance plans.

11 (2) MEDICARE BENEFICIARY.—For purposes of  
12 this section, the term “medicare beneficiary” means  
13 an individual who is eligible for benefits under part  
14 A of title XVIII of the Social Security Act and is en-  
15 rolled under part B of such title.

16 (b) CONTENTS OF THE PROPOSAL.—A proposal for  
17 legislation submitted under subsection (a) shall—

18 (1) provide for an appropriate methodology by  
19 which the Secretary shall make payment to private  
20 health insurance plans for the enrollment of medi-  
21 care beneficiaries;

22 (2) provide individuals the opportunity to re-  
23 main enrolled in such a plan without an interruption  
24 in coverage upon becoming medicare beneficiaries;  
25 and

1           (3) provide medicare beneficiaries with the op-  
2           portunity to enroll in a private health insurance  
3           plan.

4   **SEC. 7005. OPTIONAL INTERIM ENROLLMENT OF MEDICARE**  
5                   **BENEFICIARIES IN PRIVATE HEALTH PLANS.**

6           (a) INTERIM ENROLLMENT OF MEDICARE BENE-  
7           ficiaries in QUALIFIED HEALTH PLANS.—

8           (1) IN GENERAL.—Notwithstanding title XVIII  
9           of the Social Security Act, the Secretary shall pro-  
10          vide for a monthly payment as provided under sub-  
11          section (b)(1) to a private health insurance plan on  
12          behalf of enrolled medicare beneficiaries who choose  
13          to enroll in such a plan.

14          (2) MEDICARE BENEFICIARY.—For purposes of  
15          this section, the term “medicare beneficiary” means  
16          an individual who is eligible for benefits under part  
17          A of title XVIII of the Social Security Act and is en-  
18          rolled under part B of such title.

19          (b) PAYMENT SPECIFIED.—

20               (1) FEDERAL PAYMENT.—

21                   (A) IN GENERAL.—The amount of pay-  
22                   ment specified in this paragraph for an individ-  
23                   ual who is enrolled in a private health insurance  
24                   plan is the lesser of—

1 (i) the applicable rate specified in sec-  
2 tion 1876(a)(1)(C) of the Social Security  
3 Act; or

4 (ii) the monthly premium charged the  
5 individual for coverage under the private  
6 health insurance plan.

7 (B) SOURCE OF PAYMENT.—The payment  
8 to a private health insurance plan under this  
9 paragraph for individuals entitled to benefits  
10 under part A and enrolled under part B of title  
11 XVIII of the Social Security Act shall be made  
12 from the Federal Hospital Insurance Trust  
13 Fund and the Federal Supplementary Medical  
14 Insurance Trust Fund, with the allocation to be  
15 determined by the Secretary.

16 (2) INDIVIDUAL'S SHARE.—If the monthly pre-  
17 mium for the private plan in which the individual is  
18 enrolled is greater than the amount specified under  
19 paragraph (1)(A)(i), the individual shall be respon-  
20 sible for paying to the plan the difference between  
21 the monthly premium charged the individual for cov-  
22 erage under the plan and the amount specified in  
23 paragraph (1)(A)(i).

24 (3) BUDGET-NEUTRALITY.—The total amount  
25 of payments made by the Secretary under this sec-

1       tion with respect to a beneficiary for a year may not  
2       exceed the amount of payment that would have been  
3       made under title XVIII of the Social Security Act  
4       during the year if the beneficiary did not choose to  
5       enroll in a private health insurance plan during the  
6       year.

7       (c) PAYMENTS UNDER THIS SECTION AS SOLE MED-  
8       ICARE BENEFITS.—Payments made under this section  
9       shall be instead of the amounts that would otherwise be  
10      payable, pursuant to sections 1814(b) and 1833(a) of the  
11      Social Security Act, for services furnished to medicare  
12      beneficiaries.

13      (d) INCLUSION IN ANNUAL NOTICE TO BENE-  
14      FICIARIES.—Section 1804 of the Social Security Act (42  
15      U.S.C. 1395b–2), as amended by section 7003, is amend-  
16      ed—

17           (1) by striking “and” at the end of paragraph  
18           (3);

19           (2) by striking the period at the end of para-  
20           graph (4) and inserting “, and”; and

21           (3) by inserting after paragraph (4) the follow-  
22           ing new paragraph:

23           “(5) a description of the option provided pursu-  
24           ant to section 7005 of the Bipartisan Health Care  
25           Reform Act of 1994 for payment to be made by the



1 Secretary on the individual's behalf for enrollment in  
2 a private health insurance plan.”.

3 **PART 2—IMPROVED PROGRAM EFFICIENCY**

4 **SEC. 7011. IMPROVED EFFICIENCY THROUGH CONSOLIDA-**  
5 **TION OF ADMINISTRATION OF PARTS A**  
6 **AND B.**

7 (a) IN GENERAL.—The Secretary of Health and  
8 Human Services shall take such steps as may be necessary  
9 to consolidate the administration (including processing  
10 systems) of parts A and B of the medicare program (under  
11 title XVIII of the Social Security Act) over a 5-year pe-  
12 riod.

13 (b) COMBINATION OF INTERMEDIARY AND CARRIER  
14 FUNCTIONS.—In taking such steps, the Secretary shall  
15 contract with a single entity that combines the fiscal  
16 intermediary and carrier functions in each area except  
17 where the Secretary finds that special regional or national  
18 contracts are appropriate.

19 (c) SUPERSEDING CONFLICTING REQUIREMENTS.—  
20 The provisions of sections 1816 and 1842 of the Social  
21 Security Act (including provider nominating provisions in  
22 such section 1816) are superseded to the extent required  
23 to carry out this section.

1       **PART 3—NOTICE OF ADVANCE DIRECTIVE**

2                       **RIGHTS**

3   **SEC. 7021. PROVIDING NOTICE OF RIGHTS REGARDING**  
4                       **MEDICAL CARE TO INDIVIDUALS ENTERING**  
5                       **MEDICARE.**

6       (a) IN GENERAL.—Section 1804 of the Social Secu-  
7   rity Act (42 U.S.C. 1395b–2) is amended—

8               (1) in paragraph (2), by striking “and” at the  
9   end;

10             (2) in paragraph (3), by striking the period at  
11   the end and inserting “, and”; and

12             (3) by inserting after paragraph (3) the follow-  
13   ing new paragraph:

14             “(4) a description of an individual’s rights  
15   under State law to make decisions concerning medi-  
16   cal care, including the right to accept or refuse med-  
17   ical or surgical treatment and the right to formulate  
18   advance directives (as defined in section  
19   1866(f)(3)).”.

20       (b) EFFECTIVE DATE.—The amendments made by  
21   subsection (a) shall apply to notices provided under section  
22   1804 of the Social Security Act on or after January 1  
23   of the first year beginning after the date of the enactment  
24   of this Act.

## **Subtitle B—Savings**

### **PART 1—SAVINGS RELATING TO PART A**

#### **SEC. 7101. REDUCTION IN UPDATE FOR PAYMENTS FOR INPATIENT HOSPITAL SERVICES.**

Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) in subclause (XII)—

(A) by striking “fiscal year 1997” and inserting “for each of the fiscal years 1997 through 2000”, and

(B) by striking “0.5 percentage point” and inserting “2.0 percentage points”; and

(2) in subclause (XIII), by striking “fiscal year 1998” and inserting “fiscal year 2005”.

#### **SEC. 7102. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.**

(a) PPS HOSPITALS.—

(1) REDUCTION IN BASE PAYMENT RATES.—

Section 1886(g)(1)(A) of the Social Security Act (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: “In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the

1       unadjusted standard Federal capital payment rate  
2       (as described in 42 CFR 412.308(c), as in effect on  
3       the date of the enactment of the Bipartisan Health  
4       Care Reform Act of 1994) and shall reduce by 10.41  
5       percent the unadjusted hospital-specific rate (as de-  
6       scribed in 42 CFR 412.328(e)(1), as in effect on the  
7       date of the enactment of the Health Security Act).’’.

8               (2)     REDUCTION     IN     UPDATE.—Section  
9       1886(g)(1) of such Act (42 U.S.C. 1395ww(g)(1)) is  
10      amended—

11               (A) in subparagraph (B)(i)—

12                       (i) by striking “and (II)” and insert-  
13                       ing “(II)”, and

14                       (ii) by striking the semicolon at the  
15                       end and inserting the following: “, and  
16                       (III) an annual update factor established  
17                       for the prospective payment rates applica-  
18                       ble to discharges in a fiscal year which  
19                       (subject to reduction under subparagraph  
20                       (C)) will be based upon such factor as the  
21                       Secretary determines appropriate to take  
22                       into account amounts necessary for the ef-  
23                       ficient and effective delivery of medically  
24                       appropriate and necessary care of high  
25                       quality;”;

1 (B) by redesignating subparagraph (C) as  
2 subparagraph (D); and

3 (C) by inserting after subparagraph (B)  
4 the following new subparagraph:

5 “(C)(i) With respect to payments attributable  
6 to portions of cost reporting periods or discharges  
7 occurring during each of the fiscal years 1996  
8 through 2005, the Secretary shall include a reduc-  
9 tion in the annual update factor established under  
10 subparagraph (B)(i)(III) for discharges in the year  
11 equal to the applicable update reduction described in  
12 clause (ii) to adjust for excessive increases in capital  
13 costs per discharge for fiscal years prior to fiscal  
14 year 1992 (but in no event may such reduction re-  
15 sult in an annual update factor less than zero).

16 “(ii) In clause (i), the term ‘applicable update  
17 reduction’ means, with respect to the update factor  
18 for a fiscal year—

19 “(I) 4.9 percentage points; or

20 “(II) if the annual update factor for the  
21 previous fiscal year was less than the applicable  
22 update reduction for the previous year, the sum  
23 of 4.9 percentage points and the difference be-  
24 tween the annual update factor for the previous

1           year and the applicable update reduction for the  
2           previous year.”.

3           (b) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1)  
4 of such Act (42 U.S.C. 1395x(v)(1)) is further amended  
5 by adding at the end the following new subparagraph:

6           “(T) Such regulations shall provide that, in determin-  
7 ing the amount of the payments that may be made under  
8 this title with respect to the capital-related costs of inpa-  
9 tient hospital services furnished by a hospital that is not  
10 a subsection (d) hospital (as defined in section  
11 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital  
12 (as defined in section 1886(d)(9)(A)), the Secretary shall  
13 reduce the amounts of such payments otherwise estab-  
14 lished under this title by 15 percent for payments attrib-  
15 utable to portions of cost reporting periods occurring dur-  
16 ing each of the fiscal years 1996 through 2005.”.

17           **PART 2—SAVINGS RELATING TO PART B**

18           **SEC. 7111. ESTABLISHMENT OF CUMULATIVE EXPENDI-**  
19           **TURE GOALS FOR PHYSICIAN SERVICES.**

20           (a) USE OF CUMULATIVE PERFORMANCE STAND-  
21 ARD.—Section 1848(f)(2) of the Social Security Act (42  
22 U.S.C. 1395w-4(f)(2)) is amended—

23           (1) in subparagraph (A)—

1 (A) in the heading, by striking “IN GEN-  
2 ERAL” and inserting “FISCAL YEARS 1991  
3 THROUGH 1994.—”,

4 (B) in the matter preceding clause (i), by  
5 striking “a fiscal year (beginning with fiscal  
6 year 1991)” and inserting “fiscal years 1991,  
7 1992, 1993, and 1994”, and

8 (C) in the matter following clause (iv), by  
9 striking “subparagraph (B)” and inserting  
10 “subparagraph (C)”;

11 (2) in subparagraph (B), by striking “subpara-  
12 graph (A)” and inserting “subparagraphs (A) and  
13 (B)”;

14 (3) by redesignating subparagraphs (B) and  
15 (C) as subparagraphs (C) and (D); and

16 (4) by inserting after subparagraph (A) the fol-  
17 lowing new subparagraph:

18 “(B) FISCAL YEARS BEGINNING WITH FIS-  
19 CAL YEAR 1995.—Unless Congress otherwise  
20 provides, the performance standard rate of in-  
21 crease, for all physicians’ services and for each  
22 category of physicians’ services, for a fiscal year  
23 beginning with fiscal year 1995 shall be equal  
24 to the performance standard rate of increase

determined under this paragraph for the previous fiscal year, increased by the product of—

“(i) 1 plus the Secretary’s estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians’ services or for the category of physicians’ services, respectively, under this part for portions of calendar years included in the fiscal year involved,

“(ii) 1 plus the Secretary’s estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

“(iii) 1 plus the Secretary’s estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians’ services or of the category of physicians’ services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and



1           “(iv) 1 plus the Secretary’s estimate  
2           of the percentage increase or decrease (di-  
3           vided by 100) in expenditures for all physi-  
4           cians’ services or of the category of physi-  
5           cians’ services, respectively, in the fiscal  
6           year (compared with the previous fiscal  
7           year) which are estimated to result from  
8           changes in law or regulations affecting the  
9           percentage increase described in clause (i)  
10          and which is not taken into account in the  
11          percentage increase described in clause (i),  
12          minus 1, multiplied by 100, and reduced by the  
13          performance standard factor (specified in sub-  
14          paragraph (C)).”.

15       (b) TREATMENT OF DEFAULT UPDATE.—

16           (1) IN GENERAL.—Section 1848(d)(3)(B) of  
17       such Act (42 U.S.C. 1395w-4(d)(3)(B)) is amend-  
18       ed—

19           (A) in clause (i)—

20               (i) in the heading, by striking “IN  
21               GENERAL” and inserting “1992 THROUGH  
22               1996”, and

23               (ii) by striking “for a year” and in-  
24               serting “for 1992, 1993, 1994, 1995, and  
25               1996”; and

1 (B) by adding after clause (ii) the follow-  
2 ing new clause:

3 “(iii) YEARS BEGINNING WITH 1997.—

4 “(I) IN GENERAL.—The update  
5 for a category of physicians’ services  
6 for a year beginning with 1997 pro-  
7 vided under subparagraph (A) shall be  
8 increased or decreased by the same  
9 percentage by which the cumulative  
10 percentage increase in actual expendi-  
11 tures for such category of physicians’  
12 services for such year was less or  
13 greater, respectively, than the per-  
14 formance standard rate of increase  
15 (established under subsection (f)) for  
16 such category of services for such  
17 year.

18 “(II) CUMULATIVE PERCENTAGE  
19 INCREASE DEFINED.—In subclause  
20 (I), the ‘cumulative percentage in-  
21 crease in actual expenditures’ for a  
22 year shall be equal to the product of  
23 the adjusted increases for each year  
24 beginning with 1995 up to and includ-  
25 ing the year involved, minus 1 and

1 multiplied by 100. In the previous  
2 sentence, the ‘adjusted increase’ for a  
3 year is equal to 1 plus the percentage  
4 increase in actual expenditures for the  
5 year.”.

6 (2) CONFORMING AMENDMENT.—Section  
7 1848(d)(3)(A)(i) of such Act (42 U.S.C. 1395w–  
8 4(d)(3)(A)(i)) is amended by striking “subparagraph  
9 (B)” and inserting “subparagraphs (B) and (C)”.

10 (c) USE OF REAL GDP TO ADJUST FOR VOLUME  
11 AND INTENSITY.—Section 1848(f)(2)(B)(iii) of such Act  
12 (42 U.S.C. 1395w–4(f)(2)(B)(iii)), as added by subsection  
13 (a), is amended to read as follows:

14 “(iii) 1 plus the average per capita  
15 growth in the real gross domestic product  
16 (divided by 100) for the 5-fiscal-year pe-  
17 riod ending with the previous fiscal year  
18 (increased by 1.5 percentage points for the  
19 category of services consisting of primary  
20 care services), and”.

21 (d) REPEAL OF RESTRICTION ON MAXIMUM REDUC-  
22 TION.—Section 1848(d)(3)(B)(ii) of such Act (42 U.S.C.  
23 1395w–4(d)(3)(B)(ii)) is amended—

24 (1) in the heading, by inserting “IN CERTAIN  
25 YEARS” after “ADJUSTMENT”;

1           (2) in the matter preceding subclause (I), by  
2     striking “for a year”;

3           (3) in subclause (I), by adding “and” at the  
4     end;

5           (4) in subclause (II), by striking “, and” and  
6     inserting a period; and

7           (5) by striking subclause (III).

8     (e) REPEAL OF PERFORMANCE STANDARD FAC-  
9     TOR.—

10           (1) IN GENERAL.—Section 1842(f)(2) of such  
11     Act, as amended by subsection (a)(3), is amended by  
12     striking subparagraph (C) and redesignating sub-  
13     paragraph (D) as subparagraph (C).

14           (2) CONFORMING AMENDMENT.—Section  
15     1842(f)(2)(B) of such Act, as added by subsection  
16     (a), is amended in the matter following clause (iv)  
17     by striking “1, multiplied by 100” and all that fol-  
18     lows through “subparagraph (C))” and inserting “1  
19     and multiplied by 100”.

20     (f) REDUCTION IN CONVERSION FACTOR FOR PHYSI-  
21     CIAN FEE SCHEDULE FOR 1995.—Section 1848(d)(1) of  
22     the Social Security Act (42 U.S.C. 1395w-4(d)(1)) is  
23     amended—

1           (1) in subparagraph (A), by inserting after  
2           “subparagraph (B)” the following: “, and, in the  
3           case of 1995, specified in subparagraph (C)”;

4           (2) by redesignating subparagraph (C) as sub-  
5           paragraph (D); and

6           (3) by inserting after subparagraph (B) the fol-  
7           lowing new subparagraph:

8                   “(C) SPECIAL PROVISION FOR 1995.—For  
9           purposes of subparagraph (A), the conversion  
10          factor specified in this subparagraph for 1995  
11          is—

12                   “(i) in the case of physicians’ services  
13           included in the category of primary care  
14           services (as defined in subsection (j)(1)),  
15           the conversion factor established under this  
16           subsection for 1994 adjusted by the update  
17           established under paragraph (3) for 1995;  
18           and

19                   “(ii) in the case of any other physi-  
20           cians’ services, the conversion factor estab-  
21           lished under this subsection for 1994 re-  
22           duced by 3 percentage points and adjusted  
23           by the update established under paragraph  
24           (3) for 1995.”.

1 **SEC. 7112. IMPOSITION OF COINSURANCE ON LABORATORY**  
2 **SERVICES.**

3 (a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of  
4 section 1833(a) of the Social Security Act (42 U.S.C.  
5 1395l(a)) are each amended—

6 (1) by striking “(or 100 percent” and all that  
7 follows through “the first opinion))”; and

8 (2) by striking “100 percent of such negotiated  
9 rate” and inserting “80 percent of such negotiated  
10 rate”.

11 (b) EFFECTIVE DATE.—The amendments made by  
12 subsection (a) shall apply to tests furnished on or after  
13 January 1, 1995.

14 **SEC. 7113. INCREASE IN MEDICARE PART B PREMIUM FOR**  
15 **INDIVIDUALS WITH HIGH INCOME.**

16 (a) IN GENERAL.—Subchapter A of chapter 1 of the  
17 Internal Revenue Code of 1986 is amended by adding at  
18 the end thereof the following new part:

19 **“PART VIII—MEDICARE PART B PREMIUMS FOR**  
20 **HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Medicare part B premium tax.

21 **“SEC. 59B. MEDICARE PART B PREMIUM TAX.**

22 “(a) IMPOSITION OF TAX.—In the case of an individ-  
23 ual to whom this section applies for the taxable year, there  
24 is hereby imposed (in addition to any other tax imposed  
25 by this subtitle) a tax for such taxable year equal to the

1 aggregate of the Medicare part B premium taxes for each  
2 of the months during such year that such individual is  
3 covered by Medicare part B.

4 “(b) INDIVIDUALS TO WHOM SECTION APPLIES.—  
5 This section shall apply to any individual for any taxable  
6 year if—

7 “(1) such individual is covered under Medicare  
8 part B for any month during such year, and

9 “(2) the modified adjusted gross income of the  
10 taxpayer for such taxable year exceeds the threshold  
11 amount.

12 “(c) MEDICARE PART B PREMIUM TAX FOR  
13 MONTH.—

14 “(1) IN GENERAL.—The Medicare part B pre-  
15 mium tax for any month is the applicable percentage  
16 (as defined in paragraph (2)) of the amount equal  
17 to the excess of—

18 “(A) 150 percent of the monthly actuarial  
19 rate for enrollees age 65 and over determined  
20 for that calendar year under section 1839(b) of  
21 the Social Security Act, over

22 “(B) the total monthly premium under sec-  
23 tion 1839 of the Social Security Act (deter-  
24 mined without regard to subsections (b) and (f)  
25 of section 1839 of such Act).

1           “(2) PHASE-IN OF TAX.—If the modified ad-  
2           justed gross income of the taxpayer for any taxable  
3           years exceeds the threshold amount by—

4                   “(A) less than \$25,000, the applicable per-  
5                   centage under this paragraph is  $33\frac{1}{3}$  percent,

6                   “(B) at least \$25,000, but less than  
7                   \$50,000, the applicable percentage under this  
8                   paragraph is  $66\frac{2}{3}$  percent,

9                   “(C) at least \$50,000, but less than  
10                  \$75,000, the applicable percentage under this  
11                  paragraph is  $65/75$  (expressed as a percent), or

12                  “(D) at least \$75,000, the applicable per-  
13                  centage under this paragraph is 100 percent.

14           “(d) OTHER DEFINITIONS AND SPECIAL RULES.—  
15           For purposes of this section—

16                   “(1) THRESHOLD AMOUNT.—The term ‘thresh-  
17                   old amount’ means—

18                           “(A) except as otherwise provided in this  
19                           paragraph, \$75,000,

20                           “(B) \$100,000 in the case of a joint re-  
21                           turn, and

22                           “(C) zero in the case of a taxpayer who—

23                                   “(i) is married at the close of the tax-  
24                                   able year but does not file a joint return  
25                                   for such year, and



1                   “(ii) does not live apart from his  
2                   spouse at all times during the taxable year.

3                   “(2) MODIFIED ADJUSTED GROSS INCOME.—  
4                   The term ‘modified adjusted gross income’ means  
5                   adjusted gross income—

6                   “(A) determined without regard to sections  
7                   135, 911, 931, and 933, and

8                   “(B) increased by the amount of interest  
9                   received or accrued by the taxpayer during the  
10                  taxable year which is exempt from tax.

11                  “(3) MEDICARE PART B COVERAGE.—An indi-  
12                  vidual shall be treated as covered under Medicare  
13                  part B for any month if a premium is paid under  
14                  part B of title XVIII of the Social Security Act for  
15                  the coverage of the individual under such part for  
16                  the month.

17                  “(4) MARRIED INDIVIDUAL.—The determina-  
18                  tion of whether an individual is married shall be  
19                  made in accordance with section 7703.”.

20                  (b) CLERICAL AMENDMENT.—The table of parts for  
21                  subchapter A of chapter 1 of such Code is amended by  
22                  adding at the end thereof the following new item:

                  “Part VIII. Medicare Part B Premiums For High-Income Individ-  
                  uals.”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to months after December 1995  
3 in taxable years ending after December 31, 1995.

4 **SEC. 7114. EXTENSION OF 25 PERCENT PART B PREMIUM.**

5 Section 1839(e) of the Social Security Act (42 U.S.C.  
6 1395r(e)) is amended—

7 (1) in paragraph (1)(A), by striking “after after  
8 December 1995 and prior to January 1999” and in-  
9 serting “after December 1995”;

10 (2) by striking “(1)(A)” and inserting “(1)”;

11 (3) by striking paragraph (2); and

12 (4) by redesignating subparagraph (B) of para-  
13 graph (1) as paragraph (2) (and redesignating the  
14 clauses of such subparagraph accordingly).

15 **SEC. 7115. REDUCTION IN HOSPITAL OUTPATIENT SERV-**  
16 **ICES THROUGH ESTABLISHMENT OF PRO-**  
17 **SPECTIVE PAYMENT SYSTEM.**

18 (a) IN GENERAL.—Section 1833(a)(2)(B) of the So-  
19 cial Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended  
20 by striking “section 1886)—” and all that follows and in-  
21 serting the following: “section 1886), an amount equal to  
22 a prospectively determined payment rate established by  
23 the Secretary that provides for payments for such items  
24 and services to be based upon a national rate adjusted  
25 to take into account the relative costs of furnishing such

1 items and services in various geographic areas, except that  
2 for items and services furnished during cost reporting pe-  
3 riods (or portions thereof) in years beginning with 1996,  
4 such amount shall be equal to 95 percent of the amount  
5 that would otherwise have been determined;”.

6 (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT  
7 SYSTEM.—Not later than July 1, 1995, the Secretary of  
8 Health and Human Services shall establish the prospective  
9 payment system for hospital outpatient services necessary  
10 to carry out section 1833(a)(2)(B) of the Social Security  
11 Act (as amended by subsection (a)).

12 (c) EFFECTIVE DATE.—The amendment made by  
13 subsection (a) shall apply to items and services furnished  
14 on or after January 1, 1996.

15 **PART 3—SAVINGS RELATING TO PARTS A AND B**  
16 **SEC. 7121. REDUCTION IN HOME HEALTH SERVICES**  
17 **THROUGH ESTABLISHMENT OF PROSPEC-**  
18 **TIVE PAYMENT SYSTEM.**

19 (a) IN GENERAL.—

20 (1) PAYMENTS UNDER PART A.—Section 1814  
21 of the Social Security Act (42 U.S.C. 1395f) is  
22 amended—

23 (A) in subsection (b) in the matter preced-  
24 ing paragraph (1)—

1 (i) by striking “(other than” and all  
2 that follows through “medical equip-  
3 ment)”, and

4 (ii) by striking “the provisions of”  
5 and inserting “the succeeding provisions of  
6 this section and”; and

7 (B) by adding at the end the following new  
8 subsection:

9 “Payments for Home Health Services

10 “(m) The amount of payment under this part for  
11 home health services shall be equal to a prospectively de-  
12 termined payment rate established by the Secretary that  
13 provides for payments for such services to be based upon  
14 a national rate adjusted to take into account the relative  
15 costs of furnishing such services in various geographic  
16 areas, except that for services furnished during cost re-  
17 porting periods (or portions thereof) in years beginning  
18 with 1996, such amount shall be equal to 95 percent of  
19 the amount that would otherwise have been determined.”.

20 (2) PAYMENTS UNDER PART B.—Section  
21 1833(a)(2)(A) of the Social Security Act (42 U.S.C.  
22 1395l(a)(2)(A)) is amended by striking “section  
23 1861(s)(10)(A), the lesser of—” and all that follows  
24 and inserting the following: “section 1861(s)(10)(A),  
25 an amount equal to a prospectively determined pay-

1       ment rate established by the Secretary that provides  
2       for payments for such services to be based upon a  
3       national rate adjusted to take into account the rel-  
4       ative costs of furnishing such services in various geo-  
5       graphic areas, except that for services furnished dur-  
6       ing cost reporting periods (or portions thereof) in  
7       years beginning with 1996, such amount shall be  
8       equal to 95 percent of the amount that would other-  
9       wise have been determined;”.

10       (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT  
11 SYSTEM.—Not later than July 1, 1995, the Secretary of  
12 Health and Human Services shall establish the prospective  
13 payment system for home health services necessary to  
14 carry out sections 1814(m) and 1833(a)(2)(A) of the So-  
15 cial Security Act (as amended by subsection (a)).

16       (c) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) shall apply to items and services furnished  
18 on or after January 1, 1996.

19 **SEC. 7122. MEDICARE SECONDARY PAYER.**

20       (a) DELAY IN SUNSET OF DATA MATCHING RE-  
21 QUIREMENTS.—(1) Section 1862(b)(5)(C)(iii) of the So-  
22 cial Security Act (42 U.S.C. 1395y(b)(5)(C)(iii)) is  
23 amended by striking “1998” and inserting “2005”.

24       (2) Section 6103(l)(12)(F) of the Internal Revenue  
25 Code of 1986 is amended—

1 (A) in clause (i), by striking “1998” and insert-  
2 ing “2005”,

3 (B) in clause (ii)(I), by striking “1997” and in-  
4 serting “2004”, and

5 (C) in clause (ii)(II), by striking “1998” and  
6 inserting “2005”.

7 (b) EXTENSION OF MEDICARE SECONDARY PAYER  
8 TO DISABLED BENEFICIARIES.—Section  
9 1862(b)(1)(B)(iii) of the Social Security Act (42 U.S.C.  
10 1395y(b)(1)(B)(iii)) is amended by striking “1998” and  
11 inserting “2005”.

12 (c) EXTENSION OF COVERAGE FOR INDIVIDUALS  
13 WITH END STAGE RENAL DISEASE.—Section  
14 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is  
15 amended—

16 (1) in the second sentence, by striking “October  
17 1, 1998” and inserting “October 1, 1995”; and

18 (2) by adding at the end the following: “Effec-  
19 tive for items and services furnished on or after Oc-  
20 tober 1, 1995, and before October 1, 2005 (with re-  
21 spect to periods beginning on or after April 1,  
22 1994), clauses (i) and (ii) shall be applied by sub-  
23 stituting ‘24-month’ for ‘12-month’ each place it ap-  
24 pears.”.

1 (d) APPLICATION TO DISABLED BENEFICIARIES IN  
 2 ALL GROUP HEALTH PLANS.—Section 1862(b)(1)(B) of  
 3 such Act (42 U.S.C. 1395y(b)(1)(B)) is amended—

4 (1) in the heading, by striking “IN LARGE  
 5 GROUP HEALTH PLANS”;

6 (2) in clause (i), by striking “large group health  
 7 plan (as defined in clause (v))” and inserting “group  
 8 health plan (as defined in subparagraph (A)(v))”;  
 9 and

10 (3) by striking clause (iv) and inserting the fol-  
 11 lowing:

12 “(iv) SMALL EMPLOYER EXEMP-  
 13 TION.—Clauses (ii) and (iii) of subpara-  
 14 graph (A) shall apply with respect to  
 15 clause (i) in the same manner as they  
 16 apply to subparagraph (A)(i).”.

17 **TITLE VIII—INCENTIVES TO**  
 18 **PURCHASE LONG-TERM CARE**  
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1 **Subtitle A—Establishment of Fed-**  
2 **eral Standards for Long-Term**  
3 **Care Insurance**

4 **SEC. 8001. ESTABLISHMENT OF FEDERAL STANDARDS FOR**  
5 **LONG-TERM CARE INSURANCE.**

(a) IN GENERAL.—The Social Security Act, as amended by section 2101(a), is amended by adding at the end the following new title:



“TITLE XXII—LONG-TERM CARE INSURANCE  
STANDARDS

“PART A—PROMULGATION OF STANDARDS AND MODEL  
BENEFITS

“**SEC. 2201. STANDARDS.**

“(a) APPLICATION OF STANDARDS.—

“(1) NAIC.—The Secretary shall request that the National Association of Insurance Commissioners (hereinafter in this title referred to as the ‘NAIC’), in consultation with the advisory committee provided under subsection (d)—

“(A) to develop specific standards that incorporate the requirements of this title; and

“(B) to report to the Secretary on such standards,

by not later than 12 months after enactment of this title. If the NAIC develops such model standards that incorporate the requirements of this title within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under this title.

“(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Sec-

retary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this title and such standards shall apply as provided for in this title.

1           “(3) STATE STANDARDS.—

2                   “(A) IN GENERAL.—Except as provided in  
3           subparagraph (B)—

4                           “(i) a State may not establish, imple-  
5                           ment, or continue in effect standards dif-  
6                           ferent from those established under this  
7                           title;

8                           “(ii) carriers shall be exempt from  
9                           any State law, rule, regulation, or order  
10                          not meeting the requirements of this title;  
11                          and

12                          “(iii) nothing in this title shall prevent  
13                          carriers from marketing or selling long-  
14                          term care insurance policies in any State  
15                          in which the carrier is licensed to sell such  
16                          policies, if the carrier and such policies  
17                          meet the applicable requirements estab-  
18                          lished under Federal law.

19                          “(B) EXCEPTION.—

20                                  “(i) IN GENERAL.—If, upon applica-  
21                                  tion by an appropriate State agency and

1 taking into account the considerations de-  
2 scribed in clause (iii), the Secretary deter-  
3 mines that a State has a law that estab-  
4 lishes a standard which is different from  
5 the standards established under section  
6 2701(a) and the standard meets the re-  
7 quirements of clause (ii), the Secretary  
8 may permit by order or regulation imple-  
9 mentation and enforcement of the stand-  
10 ard.

11 “(ii) REQUIREMENTS FOR STAND-  
12 ARD.—The requirements of this clause are,  
13 with respect to a standard, that—

14 “(I) the standard would more ef-  
15 fectively and to an appreciable greater  
16 degree promote the availability and  
17 affordability of long-term care insur-  
18 ance than the standards established  
19 under this title,

20 “(II) the standard would not be  
21 directly inconsistent with or in conflict  
22 with the specific requirements of this  
23 title, and

24 “(III) the standard would not  
25 unduly burden interstate commerce.

1           “(iii) CONSIDERATIONS.—In permit-  
2           ting such a State standard under clause  
3           (i), the Secretary shall consider a standard  
4           favorably to the extent that the Secretary  
5           finds that following apply with respect to  
6           the standard:

7                   “(I) There will be no negative  
8                   economic impact of such a standard  
9                   on carriers and employers.

10                  “(II) The cost of complying with  
11                  the standard will be low.

12                  “(III) There will be a minimal  
13                  impact of the standard on the sol-  
14                  vency of carriers.

15                  “(IV) The standard will promote  
16                  the continuation of a competitive mar-  
17                  ket for long-term care insurance poli-  
18                  cies.

19                  “(V) There is a high probability  
20                  of other States applying for such an  
21                  exception under this subparagraph  
22                  with respect to the standard.

23                  “(VI) There will be no significant  
24                  negative impact on national uniform-

1                   ity in long-term care insurance policy  
2                   standards.

3                   “(iv) PERIODIC REVIEW.—The Sec-  
4                   retary shall periodically review the impact  
5                   of standards permitted under this subpara-  
6                   graph, taking into account the consider-  
7                   ations described in clause (iii) and the re-  
8                   quirements of clause (ii). If the Secretary  
9                   determines that a standard of a State per-  
10                  mitted under clause (i) should no longer be  
11                  permitted because it no longer meets such  
12                  requirements taking into account such con-  
13                  siderations, the Secretary, after notice and  
14                  opportunity for rebuttal by the State, may  
15                  revoke or rescind the order or regulation  
16                  permitting the State to implement the  
17                  standard.

18               “(b) DEADLINE FOR APPLICATION OF STAND-  
19               ARDS.—

20                   “(1) IN GENERAL.—Subject to paragraph (2),  
21               the date specified in this subsection for a State is—

22                   “(A) the date the State adopts the stand-  
23                   ards established under subsection (a)(1); or

24                   “(B) the date that is 1 year after the first  
25                   day of the first regular legislative session that

1 begins after the date such standards are first  
2 established under subsection (a)(2);  
3 whichever is earlier.

4 “(2) STATE REQUIRING LEGISLATION.—In the  
5 case of a State which the Secretary identifies, in  
6 consultation with the NAIC, as—

7 “(A) requiring State legislation (other than  
8 legislation appropriating funds) in order for the  
9 standards established under subsection (a) to be  
10 applied; but

11 “(B) having a legislature which is not  
12 scheduled to meet within 1 year following the  
13 beginning of the next regular legislative session  
14 in which such legislation may be considered;

15 the date specified in this subsection is the first day  
16 of the first calendar quarter beginning after the  
17 close of the first legislative session of the State legis-  
18 lature that begins on or after January 1, 1995. For  
19 purposes of the previous sentence, in the case of a  
20 State that has a 2-year legislative session, each year  
21 of such session shall be deemed to be a separate reg-  
22 ular session of the State legislature.

23 “(c) ITEMS INCLUDED IN STANDARDS.—The stand-  
24 ards promulgated under subsection (a) shall include—

1           “(1) minimum Federal standards for long-term  
2       care insurance consistent with the provisions of this  
3       title;

4           “(2) standards for the enhanced protection of  
5       consumers with long-term care insurance;

6           “(3) procedures for the modification of the  
7       standards established under paragraph (1) in a  
8       manner consistent with future laws to expand exist-  
9       ing Federal or State long-term care benefits or es-  
10      tablish a comprehensive Federal or State long-term  
11      care benefit program; and

12          “(4) other activities determined appropriate by  
13      Congress.

14          “(d) CONSULTATION.—In establishing standards and  
15      models of benefits under this section, the Secretary shall  
16      provide for and consult with an advisory committee to be  
17      chosen by the Secretary, and composed of—

18           “(1) three individuals who are representatives  
19      of carriers;

20           “(2) three individuals who are representatives  
21      of consumer groups;

22           “(3) three representatives who are representa-  
23      tives of providers of long-term care services;

24           “(4) three other individuals who are not rep-  
25      resentatives of carriers or of providers of long-term

1 care services and who have expertise in the delivery  
2 and financing of such services; and

3 “(5) the Secretary of Veterans Affairs.

4 “(e) DUTIES.—The advisory committee established  
5 under subsection (d) shall—

6 “(1) recommend the appropriate inflationary  
7 index to be used with respect to the inflation protec-  
8 tion benefit portion of the standards;

9 “(2) recommend the uniform needs assessment  
10 mechanism to be used in determining the eligibility  
11 of individuals for benefits under a policy;

12 “(3) recommend appropriate standards for ben-  
13 efits under section 2215(c); and

14 “(4) perform such other activities as deter-  
15 mined appropriate by the Secretary.

16 “(f) ADMINISTRATIVE PROVISIONS.—The following  
17 provisions of section 1886(e)(6) shall apply to the advisory  
18 committee chosen under subsection (d) in the same man-  
19 ner as such provisions apply under such section:

20 “(1) Subparagraph (C) (relating to staffing and  
21 administration).

22 “(2) Subparagraph (D) (relating to compensa-  
23 tion of members).

24 “(3) Subparagraph (F) (relating to access to  
25 information).



1           “(4) Subparagraph (G) (relating to use of  
2 funds).

3           “(5) Subparagraph (H) (relating to periodic  
4 GAO audits).

5           “(6) Subparagraph (J) (relating to requests for  
6 appropriations).

7   “PART B—ESTABLISHMENT AND IMPLEMENTATION OF  
8   LONG-TERM CARE INSURANCE POLICY STANDARDS

9   **“SEC. 2211. IMPLEMENTATION OF POLICY STANDARDS.**

10       “(a) IN GENERAL.—

11           “(1) REGULATORY PROGRAM.—No long-term  
12 care policy (as defined in section 2221) may be is-  
13 sued, sold, or offered for sale as a long-term care in-  
14 surance policy in a State on or after the date speci-  
15 fied in section 2201(b) unless—

16           “(A) the Secretary determines that the  
17 State has established a regulatory program  
18 that—

19           “(i) provides for the application and  
20 enforcement of the standards established  
21 under section 2201(a); and

22           “(ii) complies with the requirements  
23 of subsection (b);

24           by the date specified in section 2201(b), and  
25           the policy has been approved by the State com-

1           missioner or superintendent of insurance under  
2           such program; or

3           “(B) if the State has not established such  
4           a program, or if the State’s regulatory program  
5           has been decertified, the policy has been cer-  
6           tified by the Secretary (in accordance with such  
7           procedures as the Secretary may establish) as  
8           meeting the standards established under section  
9           2201(a) by the date specified in section  
10          2201(b).

11          For purposes of this subsection, the advertising or  
12          soliciting with respect to a policy, directly or indi-  
13          rectly, shall be deemed the offering for sale of the  
14          policy.

15          “(2) REVIEW OF STATE REGULATORY PRO-  
16          GRAMS.—The Secretary periodically shall review reg-  
17          ulatory programs described in paragraph (1)(A) to  
18          determine if they continue to provide for the applica-  
19          tion and enforcement of the standards and proce-  
20          dures established under section 2201(a) and (b). If  
21          the Secretary determines that a State regulatory  
22          program no longer meets such standards and re-  
23          quirements, before making a final determination, the  
24          Secretary shall provide the State an opportunity to  
25          adopt such a plan of correction as would permit the

1       program to continue to meet such standards and re-  
2       quirements. If the Secretary makes a final deter-  
3       mination that the State regulatory program, after  
4       such an opportunity, fails to meet such standards  
5       and requirements, the Secretary shall assume re-  
6       sponsibility under paragraph (1)(B) with respect to  
7       certifying policies in the State and shall exercise full  
8       authority under section 2201 for carriers, agents, or  
9       associations or its subsidiary in the State plans in  
10      the State.

11      “(b) ADDITIONAL REQUIREMENTS FOR APPROVAL  
12      OF STATE REGULATORY PROGRAMS.—For purposes of  
13      subsection (a)(1)(A)(ii), the requirements of this sub-  
14      section for a State regulatory program are as follows:

15           “(1) ENFORCEMENT.—The enforcement under  
16      the program—

17           “(A) shall be designed in a manner so as  
18           to secure compliance with the standards within  
19           30 days after the date of a finding of non-  
20           compliance with such standards;

21           “(B) shall provide for notice in the annual  
22           report required under paragraph (5) to the Sec-  
23           retary of cases where such compliance is not se-  
24           cured within such 30-day period; and

1           “(C) shall provide, in addition to any other  
2 penalties provided by the laws of a State, that  
3 any carrier, agent, or association that is found  
4 under the program to have violated such stand-  
5 ards shall each be subject to a fine of up to 3  
6 times the amount of any commissions paid for  
7 each policy involved or \$10,000, whichever is  
8 greater.

9           “(2) PROCESS.—The enforcement process  
10 under each State regulatory program shall provide  
11 for—

12           “(A) procedures for individuals and enti-  
13 ties to file written, signed complaints respecting  
14 alleged violations of the standards;

15           “(B) responding on a timely basis to such  
16 complaints;

17           “(C) the investigation of—

18           “(i) those complaints which have a  
19 reasonable probability of validity, and

20           “(ii) such other alleged violations of  
21 the standards as the program finds appro-  
22 priate; and

23           “(D) the imposition of appropriate sanc-  
24 tions (which include, in appropriate cases, the  
25 imposition of a civil money penalty as provided

1           for in section 2218) in the case of a carrier,  
2           agent, or association or its subsidiary deter-  
3           mined to have violated the standards.

4           “(3) CONSUMER ACCESS TO COMPLIANCE IN-  
5           FORMATION.—

6                   “(A) IN GENERAL.—A State regulatory  
7           program must provide for consumer access to  
8           complaints filed with the State commissioner or  
9           superintendent of insurance with respect to  
10          long-term care insurance policies.

11                   “(B) CONFIDENTIALITY.—The access pro-  
12          vided under subparagraph (A) shall be limited  
13          to the extent required to protect the confiden-  
14          tiality of the identity of individual policyholders.

15          “(4) PROCESS FOR APPROVAL OF PREMIUMS.—

16                   “(A) IN GENERAL.—Each State regulatory  
17          program shall—

18                           “(i) provide for a process for approv-  
19                          ing or disapproving proposed premium in-  
20                          creases or decreases with respect to long-  
21                          term care insurance policies; and

22                           “(ii) establish a policy for receipt and  
23                          consideration of public comments before  
24                          approving such a premium increase or de-  
25                          crease.

1           “(B) CONDITIONS FOR APPROVAL.—No  
2           premium increase shall be approved (or deemed  
3           approved) under subparagraph (A) unless the  
4           proposed increase is accompanied by an actuar-  
5           ial memorandum which—

6                   “(i) includes a description of the as-  
7                   sumptions that justify the increase;

8                   “(ii) contains such information as  
9                   may be required under the standards es-  
10                  tablished under section 2701(a); and

11                  “(iii) is made available to the public.

12           “(C) APPLICATION.—Except as provided in  
13           subparagraph (D), this paragraph shall not  
14           apply to a group long-term care insurance pol-  
15           icy issued to a group described in section  
16           4(E)(1) of the NAIC Long Term Care Insur-  
17           ance Model Act (effective January 1991), ex-  
18           cept that such group policy shall, pursuant to  
19           guidelines developed by the NAIC, provide no-  
20           tice to policyholders and certificate holders of  
21           any premium change under such group policy.

22           “(D) EXCEPTION.—Subparagraph (C)  
23           shall not apply to—

24                   “(i) group conversion policies;

1           “(ii) the group continuation feature of  
2           a group policy if the carrier separately  
3           rates employee and continuation coverages;  
4           and

5           “(iii) group policies where the func-  
6           tion of the employer is limited solely to col-  
7           lecting premiums (through payroll deduc-  
8           tions or dues checkoff) and remitting them  
9           to the carrier.

10          “(E) CONSTRUCTION.—Nothing in this  
11          paragraph shall be construed as preventing the  
12          NAIC from promulgating standards, or a State  
13          from enacting and enforcing laws, with respect  
14          to premium rates or loss ratios for all, including  
15          group, long-term care insurance policies.

16          “(5) ANNUAL REPORTS.—Each State regu-  
17          latory program shall provide for annual reports to be  
18          submitted to the Secretary on the implementation  
19          and enforcement of the standards in the State, in-  
20          cluding information concerning violations in excess  
21          of 30 days.

22          “(6) ACCESS TO OTHER INFORMATION.—The  
23          State regulatory program must provide for consumer  
24          access to actuarial memoranda provided under para-  
25          graph (4).

1           “(7) DEFAULT.—In the case of a State without  
2           a regulatory program approved under subsection (a),  
3           the Secretary shall provide for the enforcement ac-  
4           tivities described in subsection (c).

5           “(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

6           “(1) IN GENERAL.—The Secretary shall exer-  
7           cise authority under this subsection in the case of a  
8           State that does not have a regulatory program ap-  
9           proved under this section.

10           “(2) COMPLAINTS AND INVESTIGATIONS.—The  
11           Secretary shall establish procedures—

12                   “(A) for individuals and entities to file  
13                   written, signed complaints respecting alleged  
14                   violations of the requirements of this title;

15                   “(B) for responding on a timely basis to  
16                   such complaints; and

17                   “(C) for the investigation of—

18                           “(i) those complaints that have a rea-  
19                           sonable probability of validity; and

20                           “(ii) such other alleged violations of  
21                           the requirements of this title as the Sec-  
22                           retary determines to be appropriate.

23           In conducting investigations under this subsection,  
24           agents of the Secretary shall have reasonable access  
25           necessary to enable such agents to examine evidence



1 of any carrier, agent, or association or its subsidiary  
2 being investigated.

3 “(3) HEARINGS.—

4 “(A) IN GENERAL.—Prior to imposing an  
5 order described in paragraph (4) against a car-  
6 rier, agent, or association or its subsidiary  
7 under this section for a violation of the require-  
8 ments of this title, the Secretary shall provide  
9 the carrier, agent, association or subsidiary  
10 with notice and, upon request made within a  
11 reasonable time (of not less than 30 days, as  
12 established by the Secretary by regulation) of  
13 the date of the notice, a hearing respecting the  
14 violation.

15 “(B) CONDUCT OF HEARING.—Any hear-  
16 ing requested under subparagraph (A) shall be  
17 conducted before an administrative law judge.  
18 If no hearing is so requested, the Secretary’s  
19 imposition of the order shall constitute a final  
20 and unappealable order.

21 “(C) AUTHORITY IN HEARINGS.—In con-  
22 ducting hearings under this paragraph—

23 “(i) agents of the Secretary and ad-  
24 ministrative law judges shall have reason-  
25 able access necessary to enable such agents

1           and judges to examine evidence of any car-  
2           rier, agent, or association or its subsidiary  
3           being investigated; and

4           “(ii) administrative law judges, may,  
5           if necessary, compel by subpoena the at-  
6           tendance of witnesses and the production  
7           of evidence at any designated place or  
8           hearing.

9           In case of contumacy or refusal to obey a sub-  
10          poena lawfully issued under this subparagraph  
11          and upon application of the Secretary, an ap-  
12          propriate district court of the United States  
13          may issue an order requiring compliance with  
14          such subpoena and any failure to obey such  
15          order may be punished by such court as a con-  
16          tempt thereof.

17          “(D) ISSUANCE OF ORDERS.—If an admin-  
18          istrative law judge determines in a hearing  
19          under this paragraph, upon the preponderance  
20          of the evidence received, that a carrier, agent,  
21          or association or its subsidiary named in the  
22          complaint has violated the requirements of this  
23          title, the administrative law judge shall state  
24          the findings of fact and issue and cause to be

1           served on such carrier, agent, association, or  
2           subsidiary an order described in paragraph (4).

3           “(4) CEASE AND DESIST ORDER WITH CIVIL  
4           MONEY PENALTY.—

5                   “(A) IN GENERAL.—Subject to the provi-  
6           sions of subparagraphs (B) through (F), an  
7           order under this paragraph—

8                           “(i) shall require the agent, associa-  
9                           tion or its subsidiary, or a carrier—

10                                   “(I) to cease and desist from  
11                                   such violations; and

12   “(II) to pay a civil penalty in an  
13                                   amount not to exceed 3 times the  
14                                   amount of any commissions paid for  
15                                   each policy involved or \$10,000,  
16                                   whichever is greater, for each such  
17                                   violation; and

18                                   “(ii) may require the agent, associa-  
19                                   tion or its subsidiary, or a carrier to take  
20                                   such other remedial action as is appro-  
21                                   priate.

22                           “(B) CORRECTIONS WITHIN 30 DAYS.—No  
23           order shall be imposed under this paragraph by  
24           reason of any violation if the carrier, agent, or

1 association or its subsidiary establishes to the  
2 satisfaction of the Secretary that—

3 “(i) such violation was due to reason-  
4 able cause and was not intentional and was  
5 not due to willful neglect; and

6 “(ii) such violation is corrected within  
7 the 30-day period beginning on the earliest  
8 date the carrier, agent, association, or sub-  
9 sidiary knew, or exercising reasonable dili-  
10 gence could have known, that such a viola-  
11 tion was occurring.

12 “(C) WAIVER BY SECRETARY.—In the case  
13 of a violation under this title that is due to rea-  
14 sonable cause and not to willful neglect, the  
15 Secretary may waive part or all of the civil  
16 money penalty imposed under subparagraph  
17 (A)(i)(II) to the extent that payment of such  
18 penalty would be grossly excessive relative to  
19 the violation involved and to the need for deter-  
20 rence of violations.

21 “(D) ADMINISTRATIVE APPELLATE RE-  
22 VIEW.—The decision and order of an adminis-  
23 trative law judge under this paragraph shall be-  
24 come the final agency decision and order of the  
25 Secretary unless, within 30 days, the Secretary

1 modifies or vacates the decision and order, in  
2 which case the decision and order of the Sec-  
3 retary shall become a final order under this  
4 paragraph.

5 “(E) JUDICIAL REVIEW.—A carrier, agent,  
6 or association or its subsidiary or any other in-  
7 dividual adversely affected by a final order is-  
8 sued under this paragraph may, within 45 days  
9 after the date the final order is issued, file a pe-  
10 tition in the Court of Appeals for the appro-  
11 priate circuit for review of the order.

12 “(F) ENFORCEMENT OF ORDERS.—If a  
13 carrier, agent, or association or its subsidiary  
14 fails to comply with a final order issued under  
15 this paragraph against the carrier, agent, asso-  
16 ciation or subsidiary after opportunity for judi-  
17 cial review under subparagraph (E), the Sec-  
18 retary shall file a suit to seek compliance with  
19 the order in any appropriate district court of  
20 the United States. In any such suit, the validity  
21 and appropriateness of the final order shall not  
22 be subject to review.

23 **“SEC. 2212. REGULATION OF SALES PRACTICES.**

24 “(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

1           “(1) IN GENERAL.—Each agent (as defined in  
2           section 2233) or association that is selling or offer-  
3           ing for sale a long-term care insurance policy has  
4           the duty of good faith and fair dealing to the pur-  
5           chaser or potential purchaser of such a policy.

6           “(2) PROHIBITED PRACTICES.—An agent or as-  
7           sociation is considered to have violated paragraph  
8           (1) if the agent or association engages in any of the  
9           following practices:

10           “(A) TWISTING.—

11           “(i) IN GENERAL.—Knowingly making  
12           any misleading representation (including  
13           the inaccurate completion of medical his-  
14           tories) or incomplete or fraudulent com-  
15           parison of any long-term care insurance  
16           policy or carriers for the purpose of induc-  
17           ing, or tending to induce, any person to re-  
18           tain or effect a change with respect to a  
19           long-term care insurance policy.

20           “(ii) POLICY REPLACEMENT FORM.—  
21           With respect to any person who elects to  
22           replace or effect a change in a long-term  
23           care insurance policy, the individual that is  
24           selling such policy shall ensure that such  
25           person completes a policy replacement

1 form developed by the NAIC. A copy of  
2 such form shall be provided to such person  
3 and additional copies shall be delivered by  
4 the selling individual to the old policy is-  
5 suer and the new issuer and kept on file  
6 for inspection by the State regulatory  
7 agency.

8 “(B) HIGH PRESSURE TACTICS.—Employ-  
9 ing any method of marketing having the effect  
10 of, or intending to, induce the purchase of long-  
11 term care insurance policy through force, fright,  
12 threat or undue pressure, whether explicit or  
13 implicit.

14 “(C) COLD LEAD ADVERTISING.—Making  
15 use directly or indirectly of any method of mar-  
16 keting which fails to disclose in a conspicuous  
17 manner that a purpose of the method of mar-  
18 keting is solicitation of insurance and that con-  
19 tact will be made by an insurance agent or in-  
20 surance company.

21 “(D) OTHERS.—Engaging in such other  
22 practices determined inappropriate under guide-  
23 lines issued by the NAIC.

24 “(b) FINANCIAL STANDARDS.—The NAIC shall de-  
25 velop recommended financial minimum standards (includ-

1 ing both income and asset criteria) for the purpose of ad-  
2 viding individuals considering the purchase of a long-term  
3 care insurance policy.

4 “(c) PROHIBITION OF SALE OR ISSUANCE TO MEDIC-  
5 AID BENEFICIARIES.—An agent, an association, or a car-  
6 rier may not knowingly sell or issue a long-term care in-  
7 surance policy to an individual who is eligible for medical  
8 assistance under title XIX of the Social Security Act.

9 “(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLI-  
10 CATE SERVICE BENEFIT POLICIES.—An agent, associa-  
11 tion or its subsidiary, or a carrier may not sell or issue  
12 a service-benefit long-term care insurance policy to an in-  
13 dividual knowing that the policy provides for coverage that  
14 duplicates existing coverage already provided in another  
15 service-benefit long-term care insurance policy held by  
16 such individual unless—

17 “(1) the policy is intended to replace such other  
18 policy, or

19 “(2) the benefits under the new policy are fully  
20 payable directly to or on behalf of the individual  
21 without regard to other long-term care coverage of  
22 the individual.

23 In this subsection, the term ‘service-benefit long-term care  
24 insurance policy’ means a long-term care insurance policy



1 which provides for benefits based on the type and amount  
2 of services furnished.

3 “(e) PROHIBITION BASED ON ELIGIBILITY FOR  
4 OTHER BENEFITS.—A carrier may not sell or issue a  
5 long-term care insurance policy that reduces, limits or co-  
6 ordinates the benefits provided under the policy on the  
7 basis that the policyholder has or is eligible for other long-  
8 term care insurance coverage or benefits.

9 “(f) PROVISION OF OUTLINE OF COVERAGE.—No  
10 agent, association or its subsidiary, or carrier may sell or  
11 offer for a sale a long-term care insurance policy (or for  
12 a certificate under a group long-term care insurance pol-  
13 icy) without providing to the purchaser or potential pur-  
14 chaser (or representative) an outline of coverage that com-  
15 plies with the standards established under section  
16 2201(a).

17 “(g) AGENT TRAINING AND CERTIFICATION RE-  
18 QUIREMENTS.—The NAIC, shall establish requirements  
19 for long-term care insurance agent training and certifi-  
20 cation that—

21 “(1) specify requirements for training insurance  
22 agents who desire to sell or offer for sale long-term  
23 care insurance policies; and

24 “(2) specify procedures for certifying agents  
25 who have completed such training and who are as

1       qualified to sell or offer for sale long-term care in-  
2       surance policies.

3       **“SEC. 2213. ADDITIONAL RESPONSIBILITIES FOR CAR-**  
4                   **RIERS.**

5       “(a) REFUND OF PREMIUMS.—If an application for  
6 a long-term care insurance policy (or for a certificate  
7 under a group long-term care insurance policy) is denied  
8 or an applicant returns a policy or certificate within 30  
9 days of the date of its issuance pursuant to subsection  
10 2217, the carrier shall refund directly to the applicant,  
11 or in the case of an employer to whomever remits the pre-  
12 mium, and not by delivery by the agent, not later than  
13 30 days after the date of the denial or return, any pre-  
14 miums paid with respect to such a policy (or certificate).

15       “(b) MAILING OF POLICY.—If an application for a  
16 long-term care insurance policy (or for a certificate under  
17 a group long-term care insurance policy) is approved, the  
18 carrier shall provide the applicant, or in the case of a  
19 group plan the employer, the policy (or certificate) of in-  
20 surance not later than 30 days after the date of the ap-  
21 proval.

22       “(c) INFORMATION ON DENIALS OF CLAIMS.—If a  
23 claim under a long-term care insurance policy is denied,  
24 the carrier shall, within 30 days of the date of a written

1 request by the policyholder or certificate holder (or rep-  
2 resentative)—

3 “(1) provide a written explanation of the rea-  
4 sons for the denial; and

5 “(2) make available all medical and patient  
6 records directly relating to such denial.

7 Except as provided in subsection (e) of section 2215, no  
8 claim under such a policy may be denied on the basis of  
9 a failure to disclose a condition at the time of issuance  
10 of the policy if the application for the policy failed to re-  
11 quest information respecting the condition.

12 “(d) REPORTING OF INFORMATION.—A carrier that  
13 issues one or more long-term care insurance policies shall  
14 periodically (not less often than annually) report, in a  
15 form and in a manner determined by the NAIC, to the  
16 commissioner or superintendent of insurance of each State  
17 in which the policy is delivered, and shall make available  
18 to the Secretary, upon request, information in a form and  
19 manner determined by the NAIC concerning—

20 “(1) the long-term care insurance policies of the  
21 carrier that are in force;

22 “(2) the most recent premiums for such policies  
23 and the premiums imposed for such policies since  
24 their initial issuance;

1           “(3) the lapse rate, replacement rate, and re-  
2       scission rates by policy;

3           “(4) the names of that 10 percent of its agents  
4       that—

5           “(A) have the greatest lapse and replace-  
6       ment rate; and

7           “(B) have produced at least \$50,000 of  
8       long-term care insurance sales in the previous  
9       year; and

10          “(5) the claims denied (expressed as a number  
11       and as a percentage of claims submitted) by policy.

12 Information required under this subsection shall be re-  
13 ported in a format specified in the standards established  
14 under section 2201(a). For purposes of paragraph (3),  
15 there shall be included (but reported separately) data con-  
16 cerning lapses due to the death of the policyholder. For  
17 purposes of paragraph (4), there shall not be included as  
18 a claim any claim that is denied solely because of the fail-  
19 ure to meet a deductible, waiting period, or exclusionary  
20 period.

21          “(e) INFORMATION ON AGENT COMMISSIONS.—A  
22 carrier that issues one or more long-term care insurance  
23 policies shall provide to the State commissioner or super-  
24 intendent of insurance such information relating to agent  
25 sales commissions and compensation as the commissioner

1 or superintendent may require in order to monitor and  
2 make recommendations for regulatory action relating to  
3 such commissions and compensation.

4 **“SEC. 2214. RENEWABILITY STANDARDS FOR ISSUANCE,**  
5 **AND BASIS FOR CANCELLATION OF POLICIES.**

6 “(a) IN GENERAL.—No long-term care insurance pol-  
7 icy may be canceled or nonrenewed for any reason other  
8 than nonpayment of premium, material misrepresentation  
9 or fraud.

10 “(b) CONTINUATION AND CONVERSION RIGHTS FOR  
11 GROUP POLICIES.—

12 “(1) IN GENERAL.—Each group long-term care  
13 insurance policy shall provide covered individuals  
14 with a basis for continuation or conversion in ac-  
15 cordance with this subsection.

16 “(2) BASIS FOR CONTINUATION.—For purposes  
17 of paragraph (1), a policy provides a basis for con-  
18 tinuation of coverage if the policy maintains cov-  
19 erage under the existing group policy when such cov-  
20 erage would otherwise terminate and which is sub-  
21 ject only to the continued timely payment of pre-  
22 mium when due. A group policy which restricts pro-  
23 vision of benefits and services to or contains incen-  
24 tives to use certain providers or facilities, may pro-  
25 vide continuation benefits which are substantially

1 equivalent to the benefits of the existing group pol-  
2 icy.

3 “(3) BASIS FOR CONVERSION.—For purposes of  
4 paragraph (1), a policy provides a basis for conver-  
5 sion of coverage if the policy entitles each individ-  
6 ual—

7 “(A) whose coverage under the group pol-  
8 icy would otherwise be terminated for any rea-  
9 son; and

10 “(B) who has been continuously insured  
11 under the policy (or group policy which was re-  
12 placed) for at least 6 months before the date of  
13 the termination;

14 to issuance of a policy providing benefits identical to,  
15 substantially equivalent to, or in excess of, those of  
16 the policy being terminated, without evidence of in-  
17 surability.

18 “(4) TREATMENT OF SUBSTANTIAL EQUIVA-  
19 LENCE.—In determining under this subsection  
20 whether benefits are substantially equivalent, consid-  
21 eration should be given to the difference between  
22 managed care and non-managed care plans.

23 “(5) GROUP REPLACEMENT OF POLICIES.—If a  
24 group long-term care insurance policy is replaced by  
25 another long-term care insurance policy purchased

1 by the same policyholder, the succeeding issuer shall  
2 offer coverage to all persons covered under the old  
3 group policy on its date of termination. Coverage  
4 under the new group policy shall not result in any  
5 exclusion for preexisting conditions that would have  
6 been covered under the group policy being replaced.

7 “(c) STANDARDS FOR ISSUANCE.—

8 “(1) IN GENERAL.—

9 “(A) GUARANTEE.—An agent, association  
10 or carrier that sells or issues long-term care in-  
11 surance policies shall guarantee that such poli-  
12 cies shall be sold or issued to an individual, or  
13 eligible individual in the case of a group plan,  
14 if such individual meets the minimum medical  
15 underwriting requirements of such policy.

16 “(B) PREMIUM FOR CONVERTED POL-  
17 ICY.—If a group policy from which conversion  
18 is made is a replacement for a previous group  
19 policy, the premium for the converted policy  
20 shall be calculated on the basis of the insured’s  
21 age at the inception of coverage under the  
22 group policy from which conversion is made.  
23 Where the group policy from which conversion  
24 is made replaced previous group coverage, the  
25 premium for the converted policy shall be cal-

1           culated on the basis of the insured's age at in-  
2           ception of coverage under the group policy re-  
3           placed.

4           “(2) UPGRADE FOR POLICIES.—

5                 “(A) CURRENT POLICIES.—Each long-term  
6           care insurance policy in effect as of the effective  
7           date of the standards established under section  
8           2701(a) shall permit the policyholder to pur-  
9           chase a policy that complies with all such  
10          standards and the carrier shall directly inform  
11          each such policyholder of the right to purchase  
12          an upgraded policy under this paragraph.

13          “(B) FUTURE UPGRADES.—

14                 “(i) IN GENERAL.—If a carrier pro-  
15          viding a long-term care insurance policy  
16          provides for the issuance of policies with  
17          benefits that are greater than the benefits  
18          previously provided under such policies, the  
19          policyholder of a long-term care insurance  
20          policy previous issued by that carrier and  
21          still in force has the right to purchase a  
22          policy that provides for such upgraded ben-  
23          efits and the carrier shall directly inform  
24          each such policyholder of the existence of  
25          such an upgraded policy and the right to



1 purchase an upgraded policy under this  
2 paragraph.

3 “(ii) LIMITATION.—Clause (i) shall  
4 not apply to a policyholder who is eligible  
5 (or was eligible at any time within the pre-  
6 vious 6 months) for benefits under the  
7 long-term care insurance policy.

8 “(C) LIMITATION ON MEDICAL UNDER-  
9 WRITING OF UPGRADED POLICIES REQUIRED  
10 UNDER FEDERAL OR STATE LAW.—With re-  
11 spect to a long-term care insurance policy that  
12 offers upgraded benefits in accordance with a  
13 requirement of Federal or State law, the carrier  
14 issuing the policy may not impose additional  
15 medical underwriting criteria, except that—

16 “(i) the carrier may utilize an age  
17 rate for such policy, and

18 “(ii) the carrier may impose addi-  
19 tional medical underwriting criteria in rela-  
20 tion to benefits to the extent they were not  
21 included in the previously issued policy.

22 “(D) LIMITATION ON MEDICAL UNDER-  
23 WRITING ON OTHER UPGRADED POLICIES.—  
24 With respect to an upgraded long-term care in-  
25 surance policy that offers benefits that are

1 greater than the benefits required under Fed-  
2 eral or State requirements, the carrier issuing  
3 the policy—

4 “(i) except as provided in clause (ii),  
5 may not impose additional medical under-  
6 writing criteria in relation to benefits that  
7 are the same as the benefits under the pre-  
8 viously issued policy and the premiums  
9 charged with respect to such benefits may  
10 not be greater than the premiums charged  
11 with respect to such benefits under the  
12 previously issued policy, but

13 “(ii) may impose additional medical  
14 underwriting criteria in relation to benefits  
15 to the extent they were not included in the  
16 previously issued policy.

17 “(d) EFFECT OF INCAPACITATION.—

18 “(1) IN GENERAL.—

19 “(A) PROHIBITION.—Except as provided  
20 in paragraph (2), a long-term care insurance  
21 policy in effect as of the effective date of the  
22 standards established under section 2201(a)  
23 may not be canceled for nonpayment if the pol-  
24 icy holder is determined by a long-term care  
25 provider, physician or other health care pro-

1 vider, independent of the issuer of the policy, to  
2 be cognitively or mentally incapacitated so as to  
3 not make payments in a timely manner.

4 “(B) REINSTATEMENT.—A long-term care  
5 policy shall include a provision that provides for  
6 the reinstatement of such coverage, in the event  
7 of lapse, if the carrier is provided with proof of  
8 cognitive or mental incapacitation. Such rein-  
9 statement option shall remain available for a  
10 period of not less than 5 months after termi-  
11 nation and shall allow for the collection of past  
12 due premium.

13 “(2) PERMITTED CANCELLATION.—A long-term  
14 care insurance policy may be canceled under para-  
15 graph (1) for nonpayment if—

16 “(A) the period of such nonpayment is in  
17 excess of 30 days; and

18 “(B) notice of intent to cancel is provided  
19 to the policyholder or designated representative  
20 of the policy holder not less than 30 days prior  
21 to such cancellation, except that notice may not  
22 be provided until the expiration of 30 days after  
23 a premium is due and unpaid.

24 Notice under this paragraph shall be deemed to have  
25 been given as of 5 days after the mailing date.

1 **“SEC. 2215. BENEFIT STANDARDS.**

2 “(a) USE OF STANDARD DEFINITIONS AND TERMI-  
3 NOLOGY AND UNIFORM FORMAT.—Each long-term care  
4 insurance policy shall, with respect to services, providers  
5 or facilities, pursuant to standards established under sec-  
6 tion 2201(a)—

7 “(1) use uniform language and definitions, ex-  
8 cept that such language and definitions may take  
9 into account the differences between States with re-  
10 spect to definitions and terminology used for long-  
11 term care services and providers; and

12 “(2) use a uniform format for presenting the  
13 outline of coverage under such a policy;  
14 as prescribed under guidelines issued by the NAIC, after  
15 consultation with the advisory committee provided for  
16 under section 2701(d), and periodically updated.

17 “(b) DISCLOSURE.—

18 “(1) OUTLINE OF COVERAGE.—

19 “(A) REQUIREMENT.—Each carrier that  
20 sells or offers for sale a long-term care insur-  
21 ance policy shall provide an outline of coverage  
22 under such policy that meets the applicable  
23 standards established pursuant to section  
24 2201(a), complies with the requirements of sub-  
25 paragraph (B), and is in a uniform format as

1           prescribed in guidelines issued by the NAIC  
2           and periodically updated.

3           “(B) CONTENTS.—The outline of coverage  
4           for each long-term care insurance policy shall  
5           include at least the following:

6                   “(i) A description of the principal  
7                   benefits and coverage under the policy.

8                   “(ii) A statement of the principal ex-  
9                   clusions, reductions, and limitations con-  
10                  tained in the policy.

11                  “(iii) A statement of the terms under  
12                  which the policy (or certificate) may be  
13                  continued in force or discontinued, the  
14                  terms for continuation or conversion, and  
15                  any reservation in the policy of a right to  
16                  change premiums.

17                  “(iv) A statement, in bold face type  
18                  on the face of the document in language  
19                  that is understandable to an average indi-  
20                  vidual, that the outline of coverage is a  
21                  summary only, not a contract of insurance,  
22                  and that the policy (or master policy) con-  
23                  tains the contractual provisions that gov-  
24                  ern, except that such summary shall sub-

1           stantially and accurately reflect the con-  
2           tents of the policy or the master policy.

3           “(v) A description of the terms, speci-  
4           fied in section 2217, under which a policy  
5           or certificate may be returned and pre-  
6           mium refunded.

7           “(vi) A statement of the percentage  
8           limit on annual premium increases that is  
9           provided under the policy pursuant to this  
10          section.

11          “(2) CERTIFICATES.—A certificate issued pur-  
12          suant to a group long-term care insurance policy  
13          shall include—

14               “(A) a description of the principal benefits  
15               and coverage provided in the policy;

16               “(B) a statement of the principal exclu-  
17               sions, reductions, and limitations contained in  
18               the policy; and

19               “(C) a statement that the group master  
20               policy determines governing contractual provi-  
21               sions.

22          “(3) LONG-TERM CARE AS PART OF LIFE IN-  
23          SURANCE.—In the case of a long-term care insur-  
24          ance policy issued as a part of, or a rider on, a life

1 insurance policy, at the time of policy delivery there  
2 shall be provided a policy summary that includes—

3 “(A) an explanation of how the long-term  
4 care benefits interact with other components of  
5 the policy (including deductions from death  
6 benefits);

7 “(B) an illustration of the amount of bene-  
8 fits, the length of benefit, and the guaranteed  
9 lifetime benefits (if any) for each covered per-  
10 son; and

11 “(C) any exclusions, reductions, and limi-  
12 tations on benefits of long-term care.

13 “(4) ADDITIONAL INFORMATION.—The Sec-  
14 retary shall collect and distribute to each State com-  
15 missioner or superintendent of insurance on an an-  
16 nual basis information on national average costs for  
17 nursing facility and home care. This information  
18 shall be delivered to prospective policyholders of  
19 long-term care insurance policies in the following  
20 manner:

21 “(A) In the case of agent solicitations,  
22 agents shall deliver the information to prospec-  
23 tive policyholders prior to the presentation of an  
24 application or enrollment form.

1           “(B) In the case of direct response solicita-  
2           tions, the information shall be presented in con-  
3           junction with any application or enrollment  
4           form.

5           “(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM  
6 BENEFITS.—

7           “(1) IN GENERAL.—A long-term care insurance  
8           policy may not condition or limit eligibility—

9                   “(A) for benefits for a type of services to  
10           the need for or receipt of any other services;

11                   “(B) for any benefit on the medical neces-  
12           sity for such benefit;

13                   “(C) for benefits furnished by licensed or  
14           certified providers in compliance with conditions  
15           which are in addition to those required for li-  
16           censure or certification under State law, except  
17           that if no State licensure or certification laws  
18           exists, in compliance with qualifications devel-  
19           oped by the NAIC; or

20                   “(D) for residential care (if covered under  
21           the policy) only—

22                           “(i) to care provided in facilities  
23           which provide a higher level of care; or

24                           “(ii) to care provided in facilities  
25           which provide for 24-hour or other nursing



1           care not required in order to be licensed by  
2           the State.

3           “(2) HOME HEALTH CARE OR COMMUNITY-  
4       BASED SERVICES.—If a long-term care insurance  
5       policy provides benefits for the payment of specified  
6       home health care or community-based services, the  
7       policy—

8           “(A) may not limit such benefits to serv-  
9       ices provided by registered nurses or licensed  
10      practical nurses;

11          “(B) may not require benefits for such  
12      services to be provided by a nurse or therapist  
13      that can be provided by a home health aide or  
14      licensed or certified home care worker, except  
15      that if no State licensure or certification laws  
16      exists, in compliance with qualifications devel-  
17      oped by the NAIC;

18          “(C) may not limit such benefits to serv-  
19      ices provided by agencies or providers certified  
20      under title XVIII of the Social Security Act;  
21      and

22          “(D) must provide, at a minimum, benefits  
23      for personal care services (including home  
24      health aide and home care worker services as  
25      defined by the NAIC) home health services,

1 adult day care, and respite care in an individ-  
2 ual's home or in another setting in the commu-  
3 nity, or any of these benefits on a respite care  
4 basis.

5 “(3) NURSING FACILITY SERVICES.—If a long-  
6 term care insurance policy provides benefits for the  
7 payment of specified nursing facility services, the  
8 policy must provide such benefits with respect to all  
9 nursing facilities (as defined in section 1919(a) or  
10 until such time as subsequently provided for by the  
11 NAIC in establishing uniform language and defini-  
12 tions under section 2215(a)(1)) in the State.

13 “(4) PER DIEM POLICIES.—

14 “(A) DEFINITION.—For purposes of this  
15 title, the term ‘per diem long-term care insur-  
16 ance policy’ means a long-term care insurance  
17 policy (or certificate under a group long-term  
18 care insurance policy) that provides for benefit  
19 payments on a periodic basis due to cognitive  
20 impairment or loss of functional capacity with-  
21 out regard to the expenses incurred or services  
22 rendered during the period to which the pay-  
23 ments relate.

24 “(B) LIMITATION.—No per diem long-term  
25 care insurance policy (or certificate) may condi-

1           tion or otherwise exclude benefit payments  
2           based on the receipt of any type of nursing fa-  
3           cility, home health care or community-based  
4           services.

5           “(d) PROHIBITION OF DISCRIMINATION.—A long-  
6 term care insurance policy may not treat benefits under  
7 the policy in the case of an individual with Alzheimer’s  
8 disease, with any related progressive degenerative demen-  
9 tia of an organic origin, with any organic or inorganic  
10 mental illness, or with mental retardation or any other  
11 cognitive or mental impairment differently from an indi-  
12 vidual having another medical condition for which benefits  
13 may be made available.

14           “(e) LIMITATION ON USE OF PREEXISTING CONDI-  
15 TION LIMITS.—

16           “(1) INITIAL ISSUANCE.—

17                   “(A) IN GENERAL.—Subject to subpara-  
18 graph (B), a long-term care insurance policy  
19 may not exclude or condition benefits based on  
20 a medical condition for which the policyholder  
21 received treatment or was otherwise diagnosed  
22 before the issuance of the policy.

23                   “(B) 6-MONTH LIMIT.—

24                           “(i) IN GENERAL.—No long-term care  
25 insurance policy or certificate issued under

1           this title shall utilize a definition of ‘pre-  
2           existing condition’ that is more restrictive  
3           than the following: The term ‘preexisting  
4           condition’ means a condition for which  
5           medical advice or treatment was rec-  
6           ommended by, or received from a provider  
7           of health care services, within 6 months  
8           preceding the effective date of coverage of  
9           an insured individual.

10           “(ii) PROHIBITION ON EXCLUSION OF  
11           COVERAGE.—No long-term care insurance  
12           policy or certificate may exclude coverage  
13           for a loss or confinement that is the result  
14           of a preexisting condition unless such loss  
15           or confinement begins within 6 months fol-  
16           lowing the effective date of the coverage of  
17           the insured individual.

18           “(2) REPLACEMENT POLICIES.—If a long-term  
19           care insurance policy replaces another long-term  
20           care insurance policy, the issuer of the replacing pol-  
21           icy shall waive any time periods applicable to pre-  
22           existing conditions, waiting period, elimination peri-  
23           ods and probationary periods in the new policy for  
24           similar benefits to the extent such time was spent  
25           under the original policy.

1 “(f) ELIGIBILITY FOR BENEFITS.—

2 “(1) LONG-TERM CARE POLICIES.—Each long-  
3 term care insurance policy shall—

4 “(A) describe the level of benefits available  
5 under the policy; and

6 “(B) specify in clear, understandable  
7 terms, the level (or levels) of physical, cognitive,  
8 or mental impairment required in order to re-  
9 ceive benefits under the policy.

10 “(2) FUNCTIONAL ASSESSMENT.—In order to  
11 submit a claim under any long-term care insurance  
12 policy, each claimant shall have a professional func-  
13 tional assessment of his or her physical, cognitive,  
14 and mental abilities. Such initial assessment shall be  
15 conducted by an individual or entity, meeting the  
16 qualifications established by the NAIC to assure the  
17 professional competence and credibility of such indi-  
18 vidual or entity and that such individual meets any  
19 applicable State licensure and certification require-  
20 ments. The individual or entity conducting such as-  
21 sessment may not control, or be controlled by, the  
22 issuer of the policy. For purposes of this paragraph  
23 and paragraph (4), the term ‘control’ means the di-  
24 rect or indirect possession of the power to direct the  
25 management and policies of a person. Control is pre-

1       sumed to exist, if any person directly or indirectly,  
2       owns, controls, holds with the power to vote, or  
3       holds proxies representing 10 percent of the voting  
4       securities of another person.

5           “(3) CLAIMS REVIEW.—Except as provided in  
6       paragraph (4), each long-term care insurance policy  
7       shall be subject to final claims review by the carrier  
8       pursuant to the terms of the long-term care insur-  
9       ance policy.

10          “(4) APPEALS PROCESS.—

11           “(A) IN GENERAL.—Each long-term care  
12       insurance policy shall provide for a timely and  
13       independent appeals process, meeting standards  
14       established by the NAIC, for individuals who  
15       dispute the results of the claims review, con-  
16       ducted under paragraph (3), of the claimant’s  
17       functional assessment, conducted under para-  
18       graph (2).

19           “(B) INDEPENDENT ASSESSMENT.—An  
20       appeals process under this paragraph shall in-  
21       clude, at the request of the claimant, an inde-  
22       pendent assessment of the claimant’s physical,  
23       cognitive or mental abilities.

24           “(C) CONDUCT.—An independent assess-  
25       ment under subparagraph (B) shall be con-

1           ducted by an individual or entity meeting the  
2           qualifications established by the NAIC to as-  
3           sure the professional competence and credibility  
4           of such individual or entity and any applicable  
5           State licensure and certification requirements  
6           and may not be conducted—

7                   “(i) by an individual who has a direct  
8                   or indirect significant or controlling inter-  
9                   est in, or direct affiliation or relationship  
10                  with, the issuer of the policy;

11                  “(ii) by an entity that provides serv-  
12                  ices to the policyholder or certificateholder  
13                  for which benefits are available under the  
14                  long-term care insurance policy; or

15                  “(iii) by an individual or entity in con-  
16                  trol of, or controlled by, the issuer of the  
17                  policy.

18           “(5) STANDARD ASSESSMENTS.—Not later than  
19           2 years after the date of enactment of this title, the  
20           advisory committee established under section  
21           2201(d) shall recommend uniform needs assessment  
22           mechanisms for the determination of eligibility for  
23           benefits under such assessments.

24           “(g) INFLATION PROTECTION.—

1           “(1) OPTION TO PURCHASE.—A carrier may  
2           not offer a long-term care insurance policy unless  
3           the carrier also offers to the proposed policyholder,  
4           including each group policyholder, the option to pur-  
5           chase a policy that provides for increases in benefit  
6           levels, with benefit maximums or reasonable dura-  
7           tions that are meaningful, to account for reasonably  
8           anticipated increases in the costs of long-term care  
9           services covered by the policy. A carrier may not  
10          offer to a policyholder an inflation protection feature  
11          that is less favorable to the policyholder than one of  
12          the following:

13                 “(A) With respect to policies that provide  
14                 for automatic periodic increases in benefits, the  
15                 policy provides for an annual increase in bene-  
16                 fits in a manner so that such increases are  
17                 computed annually at a rate of not less than 5  
18                 percent.

19                 “(B) With respect to policies that provide  
20                 for periodic opportunities to elect an increase in  
21                 benefits, the policy guarantees that the insured  
22                 individual will have the right to periodically in-  
23                 crease the benefit levels under the policy with-  
24                 out providing evidence of insurability or health  
25                 status so long as the option for the previous pe-



1           riod was not declined. The amount of any such  
2           additional benefit may not be less than the dif-  
3           ference between—

4                   “(i) the existing policy benefit; and

5                   “(ii) such existing benefit compounded  
6                   annually at a rate of at least 5 percent for  
7                   the period beginning on the date on which  
8                   the existing benefit is purchased and ex-  
9                   tending until the year in which the offer of  
10                  increase is made.

11               “(C) With respect to service benefit poli-  
12               cies, the policy covers a specified percentage of  
13               the actual or reasonable charges and does not  
14               include a maximum specified indemnity amount  
15               or limit.

16               “(2) EXCEPTION.—The requirements of para-  
17               graph (1) shall not apply to life insurance policies or  
18               riders containing accelerated long-term care benefits.

19               “(3) REQUIRED INFORMATION.—Carriers shall  
20               include the following information in or together with  
21               the outline of coverage provided under this title:

22                   “(A) A graphic comparison of the benefit  
23                   levels of a policy that increases benefits over the  
24                   policy period with a policy that does not in-  
25                   crease benefits. Such comparison shall show

1 benefit levels over not less than a 20-year pe-  
2 riod.

3 “(B) Any expected premium increases or  
4 additional premiums required to pay for any  
5 automatic or optional benefit increases, whether  
6 the individual who purchases the policy obtains  
7 the inflation protection initially or whether such  
8 individual delays purchasing such protection  
9 until a future time.

10 “(4) CONTINUATION OF PROTECTION.—Infla-  
11 tion protection benefit increases under this sub-  
12 section under a policy that contains such protection  
13 shall continue without regard to an insured’s age,  
14 claim status or claim history, or the length of time  
15 the individual has been insured under the policy.

16 “(5) CONSTANT PREMIUM.—An offer of infla-  
17 tion protection under this subsection that provides  
18 for automatic benefit increases shall include an offer  
19 of a premium that the carrier expects to remain con-  
20 stant. Such offer shall disclose in a conspicuous  
21 manner that the premium may change in the future  
22 unless the premium is guaranteed to remain con-  
23 stant.

24 “(6) REJECTION.—Inflation protection under  
25 this subsection shall be included in a long-term care

1 insurance policy unless a carrier obtains a written  
2 rejection of such protection signed by the policy-  
3 holder.

4 **“SEC. 2216. OFFER OF NONFORFEITURE BENEFITS.**

5 “The issuer of a long-term care insurance policy shall  
6 offer to the policyholder (including any certificate holder  
7 under the policy) a nonforfeiture benefit provision that  
8 meets the following requirements:

9 “(1) The provision is appropriately captioned.

10 “(2) The provision provides for a benefit avail-  
11 able in the event of a default in the payment of any  
12 premiums and the amount of such benefit may be  
13 adjusted subsequent to being initially granted only  
14 as necessary to reflect changes in claims, persist-  
15 ency, and interest as reflected in changes in pre-  
16 miums rates. The percent or amount of benefits  
17 shall increase based upon the policyholder’s equity in  
18 the policy.

19 “(3) The provision includes at least one of the  
20 following:

21 “(A) Reduced paid-up insurance.

22 “(B) Extended term insurance.

23 “(C) Shortened benefit period.

1           “(D) Another similar offering specified  
2           under the standards established under section  
3           2701(a).

4   **“SEC. 2217. LIMIT OF PERIOD OF CONTESTABILITY AND**  
5           **RIGHT TO RETURN.**

6           “(a) CONTESTABILITY.—A carrier may not cancel or  
7   renew a long-term care insurance policy or deny a claim  
8   under the policy based on fraud or material misrepresenta-  
9   tion relating to the issuance of the policy unless notice  
10   of such fraud or material misrepresentation is provided  
11   within a time period to be determined by the NAIC.

12          “(b) RIGHT TO RETURN.—Each applicant for a long-  
13   term care insurance policy shall have the right to return  
14   the policy (or certificates) within 30 days of the date of  
15   its delivery (and to have the premium refunded) if, after  
16   examination of the policy or certificate, the applicant is  
17   not satisfied for any reason.

18   **“SEC. 2218. CIVIL MONEY PENALTY.**

19          “(a) CARRIER.—Any carrier, association or its sub-  
20   sidiary that sells or offers for sale a long-term care insur-  
21   ance policy and that—

22               “(1) fails to make a refund in accordance with  
23               section 2213(a);

24               “(2) fails to transmit a policy in accordance  
25               with section 2213(b);

1           “(3) fails to provide, make available, or report  
2           information in accordance with subsections (c), (d),  
3           or (e) of section 2213;

4           “(4) fails to provide an outline of coverage in  
5           violation of section 2215(b)(1); or

6           “(5) issues a policy without obtaining certain  
7           information in violation of section 2215(f);

8           is subject to a civil money penalty of not to exceed \$25,000  
9           for each such violation.

10          “(b) AGENTS.—Any agent that sells or offers for sale  
11          a long-term care insurance policy and that—

12               “(1) fails to make a refund in accordance with  
13               section 2213(a);

14               “(2) fails to transmit a policy in accordance  
15               with section 2213(b);

16               “(3) fails to provide, make available, or report  
17               information in accordance with subsections (c) or (d)  
18               of section 2213;

19               “(4) fails to provide an outline of coverage in  
20               violation of section 2215(b)(1); or

21               “(5) issues a policy without obtaining certain  
22               information in violation of section 2215(f);

23           is subject to a civil money penalty of not to exceed \$15,000  
24           for each such violation.

1 “PART C—LONG-TERM CARE INSURANCE POLICIES,  
2 DEFINITION AND ENDORSEMENTS

3 “**SEC. 2221. LONG-TERM CARE INSURANCE POLICY DE-**  
4 **FINED.**

5 “(a) IN GENERAL.—As used in this section, the term  
6 ‘long-term care insurance policy’ means any insurance pol-  
7 icy, rider or certificate advertised, marketed, offered or de-  
8 signed to provide coverage for not less than 12 consecutive  
9 months for each covered person on an expense incurred,  
10 indemnity prepaid or other basis, for one or more nec-  
11 essary diagnostic, preventive, therapeutic, rehabilitative,  
12 maintenance or personal care services, provided in a set-  
13 ting other than an acute care unit of a hospital. Such term  
14 includes—

15 “(1) group and individual annuities and life in-  
16 surance policies, riders or certificates that provide  
17 directly, or that supplement long-term care insur-  
18 ance; and

19 “(2) a policy, rider or certificates that provides  
20 for payment of benefits based on cognitive impair-  
21 ment or the loss of functional capacity.

22 “(b) ISSUANCE.—Long-term care insurance policies  
23 may be issued by—

24 “(1) carriers;

25 “(2) fraternal benefit societies;

1           “(3) nonprofit health, hospital, and medical  
2           service corporations;

3           “(4) prepaid health plans;

4           “(5) health maintenance organizations; or

5           “(6) any similar organization to the extent they  
6           are otherwise authorized to issue life or health insur-  
7           ance.

8           “(c) POLICIES EXCLUDED.—The term ‘long-term  
9           care insurance policy’ shall not include any insurance pol-  
10          icy, rider or certificate that is offered primarily to provide  
11          basic Medicare supplement coverage, basic hospital ex-  
12          pense coverage, basic medical-surgical expense coverage,  
13          hospital confinement indemnity coverage, major medical  
14          expense coverage, disability income or related asset-protec-  
15          tion coverage, accident only coverage, specified disease or  
16          specified accident coverage, or limited benefit health cov-  
17          erage. With respect to life insurance, such term shall not  
18          include life insurance policies, riders or certificates that  
19          accelerate the death benefit specifically for one or more  
20          of the qualifying events of terminal illness, medical condi-  
21          tions requiring extraordinary medical intervention, or per-  
22          manent institutional confinement, and that provide the op-  
23          tion of a lump-sum payment for those benefits and in  
24          which neither the benefits nor the eligibility for the bene-  
25          fits is conditioned upon the receipt of long-term care.

1       “(d) APPLICATIONS.—Notwithstanding any other  
2 provision of this title, this title shall apply to any product  
3 advertised, marketed or offered as a long-term insurance  
4 policy, rider or certificate.

5       **“SEC. 2222. CODE OF CONDUCT WITH RESPECT TO EN-**  
6                               **DORSEMENTS.**

7       “Not later than 1 year after the date of enactment  
8 of this title the NAIC shall issue guidelines that shall  
9 apply to organizations and associations, other than em-  
10 ployers and labor organizations that do not accept com-  
11 pensation, and their subsidiaries that provide endorse-  
12 ments of long-term care insurance policies, or that permit  
13 such policies to be offered for sale through the organiza-  
14 tion or association. Such guidelines shall include at mini-  
15 mum the following:

16               “(1) In endorsing or selling long-term care in-  
17 surance policies, the primary responsibility of an or-  
18 ganization or association shall be to educate their  
19 members concerning such policies and assist such  
20 members in making informed decisions. Such organi-  
21 zations and associations may not function primarily  
22 as sales agents for insurance companies.

23               “(2) Organizations and associations shall pro-  
24 vide objective information regarding long-term care  
25 insurance policies sold or endorsed by such organiza-



1        tions and associations to ensure that members of  
2        such organizations and associations have a balanced  
3        and complete understanding of both the strengths  
4        and weaknesses of the policies that are being en-  
5        dorsed or sold.

6            “(3) Organizations and associations selling or  
7        endorsing long-term care insurance policies shall dis-  
8        close in marketing literature provided to their mem-  
9        bers concerning such policies the manner in which  
10       such policies and the insurance company issuing  
11       such policies were selected. If the organization or as-  
12       sociation and the insurance company have interlock-  
13       ing directorates, the organization or association shall  
14       disclose such fact to their members.

15           “(4) Organizations and associations selling or  
16       endorsing long-term care insurance policies shall dis-  
17       close in marketing literature provided to their mem-  
18       bers concerning such policies the nature and amount  
19       of the compensation arrangements (including all  
20       fees, commissions, administrative fees and other  
21       forms of financial support that the organization or  
22       association receives) from the endorsement or sale of  
23       the policy to its members.

24           “(5) The Boards of Directors of organizations  
25       and associations selling or endorsing long-term care

1 insurance policies, if such organizations and associa-  
2 tions have a Board of Directors, shall review and ap-  
3 prove such insurance policies, the compensation ar-  
4 rangements and the marketing materials used to  
5 promote sales of such policies.

6 “PART D—MISCELLANEOUS PROVISIONS

7 “**SEC. 2231. DEFINITIONS.**

8 “As used in this title:

9 “(1) AGENT.—The term ‘agent’ means—

10 “(A) prior to 2 years after the date of en-  
11 actment of this Act, an individual who sells or  
12 offers for sale a long-term care insurance policy  
13 subject to the requirements of this title and is  
14 licensed or required to be licensed under State  
15 law for such purpose; and

16 “(B) after the date referred to in subpara-  
17 graph (A), an individual who meets the training  
18 and certification requirements established under  
19 section 2212(f).

20 “(2) ASSOCIATION.—The term ‘association’ in-  
21 cludes the association and its subsidiaries.

22 “(3) CARRIER.—The term ‘carrier’ means any  
23 person that offers a health benefit plan, whether  
24 through insurance or otherwise, including a licensed  
25 insurance company, a prepaid hospital or medical

1 service plan, a health maintenance organization, a  
2 self-insured carrier, a reinsurance carrier, and a  
3 multiple employer welfare arrangement (a combina-  
4 tion of employers associated for the purpose of pro-  
5 viding health benefit plan coverage for their employ-  
6 ees).”.

## 7 **Subtitle B—Tax Treatment of Long-** 8 **Term Care Insurance**

### 9 **SEC. 8101. TREATMENT OF LONG-TERM CARE INSURANCE** 10 **OR PLANS.**

11 (a) GENERAL RULE.—Subpart E of part I of sub-  
12 chapter L of chapter 1 of the Internal Revenue Code of  
13 1986 is amended by inserting after section 818 the follow-  
14 ing new section:

### 15 **“SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE** 16 **OR PLANS.**

17 “(a) GENERAL RULE.—For purposes of this part, a  
18 long-term care insurance contract shall be treated as an  
19 accident or health insurance contract.

20 “(b) LONG-TERM CARE INSURANCE CONTRACT.—

21 “(1) IN GENERAL.—For purposes of this part,  
22 the term ‘long-term care insurance contract’ means  
23 any insurance contract issued if—

24 “(A) the only insurance protection pro-  
25 vided under such contract is coverage of quali-

1           fied long-term care services and benefits inci-  
2           dental to such coverage,

3           “(B) the maximum benefit under the pol-  
4           icy for expenses incurred for any day does not  
5           exceed \$200,

6           “(C) such contract does not cover expenses  
7           incurred for services or items to the extent that  
8           such expenses are reimbursable under title  
9           XVIII of the Social Security Act or would be so  
10          reimbursable but for the application of a de-  
11          ductible or coinsurance amount,

12          “(D) such contract is guaranteed renew-  
13          able,

14          “(E) such contract does not have any cash  
15          surrender value, and

16          “(F) all refunds of premiums, and all pol-  
17          icyholder dividends or similar amounts, under  
18          such contract are to be applied as a reduction  
19          in future premiums or to increase future bene-  
20          fits.

21          “(2) SPECIAL RULES.—

22          “(A) PER DIEM, ETC. PAYMENTS PER-  
23          MITTED.—A contract shall not fail to be treated  
24          as described in paragraph (1)(A) by reason of  
25          payments being made on a per diem or other

1           periodic basis without regard to the expenses  
2           incurred during the period to which the pay-  
3           ments relate.

4           “(B) CONTRACT MAY COVER MEDICARE  
5           REIMBURSABLE EXPENSES WHERE MEDICARE  
6           IS SECONDARY PAYOR.—Paragraph (1)(C) shall  
7           not apply to expenses which are reimbursable  
8           under title XVIII of the Social Security Act  
9           only as a secondary payor.

10          “(C) REFUNDS OF PREMIUMS.—Paragraph  
11          (1)(F) shall not apply to any refund of pre-  
12          miums on surrender or cancellation of the con-  
13          tract.

14          “(3) TREATMENT OF COVERAGE PROVIDED AS  
15          PART OF A LIFE INSURANCE CONTRACT.—Except as  
16          otherwise provided in regulations prescribed by the  
17          Secretary, in the case of any long-term care insur-  
18          ance coverage provided by rider on a life insurance  
19          contract—

20                 “(A) IN GENERAL.—This subsection shall  
21                 be applied as if the portion of the contract pro-  
22                 viding such coverage were a separate contract.

23                 “(B) PREMIUMS AND CHARGES FOR LONG-  
24                 TERM CARE COVERAGE.—Premium payments  
25                 for coverage under a long-term care insurance

1 contract and charges against the life insurance  
2 contract's cash surrender value (within the  
3 meaning of section 7702(f)(2)(A)) for such cov-  
4 erage shall be treated as premiums for purposes  
5 of paragraph (1)(F).

6 “(C) APPLICATION OF SECTION 7702.—  
7 Section 7702(c)(2) (relating to the guideline  
8 premium limitation) shall be applied by increas-  
9 ing the guideline premium limitation with re-  
10 spect to a life insurance contract, as of any  
11 date, by the excess of—

12 “(i) the sum of any charges (but not  
13 premium payments) described in subpara-  
14 graph (B) made on or before such date  
15 under the contract, over

16 “(ii) any such charges the imposition  
17 of which reduces the premiums paid for  
18 the contract (within the meaning of section  
19 7702(f)(1)).

20 “(D) APPLICATION OF SECTION 213.—No  
21 deduction shall be allowed under section 213(a)  
22 for charges against the life insurance contract's  
23 cash surrender value described in subparagraph  
24 (B), unless such charges are includible in in-  
25 come as a result of the application of section

1           72(e)(10) and the coverage provided by the  
2           rider is a long-term care insurance contract  
3           under subsection (b)(1).

4           “(E) AMOUNT OF DISTRIBUTION UNDER  
5           RIDER.—This paragraph shall not apply to any  
6           rider on a life insurance contract unless the  
7           percentage reduction in the cash surrender  
8           value of the contract by reason of any payment  
9           under the rider does not exceed the percentage  
10          reduction in the death benefit payable under  
11          the contract by reason of the payment.

12          For purposes of this paragraph, the term ‘portion’  
13          means only the terms and benefits under a life in-  
14          surance contract that are in addition to the terms  
15          and benefits under the contract without regard to  
16          the coverage under a long-term care insurance con-  
17          tract, except that the coverage under a rider de-  
18          scribed in this paragraph shall not fail to be treated  
19          as such an addition by reason of a reduction in the  
20          contract’s death benefit or cash surrender value re-  
21          sulting from any payment under the rider.

22          “(c) QUALIFIED LONG-TERM CARE SERVICES.—For  
23          purposes of this section—

24               “(1) IN GENERAL.—The term ‘qualified long-  
25          term care services’ means necessary diagnostic, pre-

1       ventive, therapeutic, and rehabilitative services, and  
2       maintenance or personal care services, which—

3               “(A) are required by a chronically ill indi-  
4       vidual in a qualified facility, and

5               “(B) are provided pursuant to a plan of  
6       care prescribed by a licensed health care practi-  
7       tioner.

8       “(2) CHRONICALLY ILL INDIVIDUAL.—

9               “(A) IN GENERAL.—The term ‘chronically  
10      ill individual’ means any individual who has  
11      been certified by a licensed health care practi-  
12      tioner as—

13               “(i) (I) being unable to perform (with-  
14      out substantial assistance from another in-  
15      dividual) at least 2 activities of daily living  
16      (as defined in subparagraph (B)) for a pe-  
17      riod of at least 90 days due to a loss of  
18      functional capacity, or

19               “(II) having a level of disability simi-  
20      lar (as determined by the Secretary in con-  
21      sultation with the Secretary of Health and  
22      Human Services) to the level of disability  
23      described in subclause (I), or

24               “(ii) having a similar level of disabil-  
25      ity due to cognitive impairment.



1           “(B) ACTIVITIES OF DAILY LIVING.—For  
2           purposes of subparagraph (A), each of the fol-  
3           lowing is an activity of daily living:

4                   “(i) MOBILITY.—The process of walk-  
5                   ing or wheeling on a level surface which  
6                   may include the use of an assistive device  
7                   such as a cane, walker, wheelchair, or  
8                   brace.

9                   “(ii) DRESSING.—The overall complex  
10                  behavior of getting clothes from closets  
11                  and drawers and then getting dressed.

12                  “(iii) TOILETING.—The act of going  
13                  to the toilet room for bowel and bladder  
14                  function, transferring on and off the toilet,  
15                  cleaning after elimination, and arranging  
16                  clothes or the ability to voluntarily control  
17                  bowel and bladder function, or in the event  
18                  of incontinence, the ability to maintain a  
19                  reasonable level of personal hygiene.

20                  “(iv) TRANSFER.—The process of get-  
21                  ting in and out of bed or in and out of a  
22                  chair or wheelchair.

23                  “(v) EATING.—The process of getting  
24                  food from a plate or its equivalent into the  
25                  mouth.

1           “(3) QUALIFIED FACILITY.—The term ‘quali-  
2       fied facility’ means—

3           “(A) a nursing, rehabilitative, hospice, or  
4       adult day care facility (including a hospital, re-  
5       tirement home, nursing home, skilled nursing  
6       facility, intermediate care facility, or similar in-  
7       stitution)—

8           “(i) which is licensed under State law,  
9       or

10          “(ii) which is a certified facility for  
11       purposes of title XVIII or XIX of the So-  
12       cial Security Act, or

13          “(B) an individual’s home if a licensed  
14       health care practitioner certifies that without  
15       home care the individual would have to be cared  
16       for in a facility described in subparagraph (A).

17          “(4) MAINTENANCE OR PERSONAL CARE SERV-  
18       ICES.—The term ‘maintenance or personal care serv-  
19       ices’ means any care the primary purpose of which  
20       is to provide needed assistance with any of the ac-  
21       tivities of daily living described in paragraph (2)(B).

22          “(5) LICENSED HEALTH CARE PRACTI-  
23       TIONER.—The term ‘licensed health care practi-  
24       tioner’ means any physician (as defined in section  
25       1861(r) of the Social Security Act) and any reg-

1       istered professional nurse, licensed social worker, or  
2       other individual who meets such requirements as  
3       may be prescribed by the Secretary.

4       “(d) CONTINUATION COVERAGE EXCISE TAX NOT  
5 TO APPLY.—This section shall not apply in determining  
6 whether section 4980B (relating to failure to satisfy con-  
7 tinuation coverage requirements of group health plans) ap-  
8 plies.

9       “(e) INFLATION ADJUSTMENT OF \$200 BENEFIT  
10 LIMIT.—

11           “(1) IN GENERAL.—In the case of a calendar  
12 year after 1994, the \$200 amount contained in sub-  
13 section (b)(1)(B) shall be increased for such cal-  
14 endar year by the medical care cost adjustment for  
15 such calendar year. If any increase determined  
16 under the preceding sentence is not a multiple of  
17 \$10, such increase shall be rounded to the nearest  
18 multiple of \$10.

19           “(2) MEDICAL CARE COST ADJUSTMENT.—For  
20 purposes of paragraph (1), the medical care cost ad-  
21 justment for any calendar year is the percentage (if  
22 any) by which—

23           “(A) the medical care component of the  
24 Consumer Price Index (as defined in section

1           1(f)(5)) for August of the preceding calendar  
2           year, exceeds

3           “(B) such component for August of 1993.”

4           (b) RESERVES.—Clause (iii) of section 807(d)(3)(A)  
5 of such Code is amended by inserting “(other than a long-  
6 term care insurance contract within the meaning of sec-  
7 tion 818A)” after “contract”.

8           (c) CLERICAL AMENDMENT.—The table of sections  
9 for subpart E of part I of subchapter L of chapter 1 of  
10 such Code is amended by inserting after the item relating  
11 to section 818 the following new item:

“Sec. 818A. Treatment of long-term care insurance or plans.”

12 **SEC. 8102. EXCLUSION FOR BENEFITS PROVIDED UNDER**  
13 **LONG-TERM CARE INSURANCE AND FOR CER-**  
14 **TAIN EMPLOYER-PROVIDED COVERAGE.**

15           (a) IN GENERAL.—Subsection (a) of section 104 of  
16 the Internal Revenue Code of 1986 (relating to compensa-  
17 tion for injuries or sickness) is amended by striking “and”  
18 at the end of paragraph (4), by striking the period at the  
19 end of paragraph (5) and inserting “, and”, and by insert-  
20 ing after paragraph (5) the following new paragraph:

21           “(6) benefits under a long-term care insurance  
22 contract (as defined in section 818A(b)).”

23           (b) EMPLOYER-PROVIDED COVERAGE.—Section 106  
24 of such Code (relating to contributions by employer to ac-  
25 cident and health plans), as amended by section 2003, is

1 amended by adding at the end the following new sub-  
2 section:

3 “(c) TREATMENT OF LONG-TERM CARE INSURANCE  
4 CONTRACTS.—

5 “(1) IN GENERAL.—Except as provided in para-  
6 graph (2), a long-term care insurance contract (as  
7 defined in section 818A(b)) shall be treated as a  
8 health plan for purposes of subsection (a).

9 “(2) EXCEPTION FOR CAFETERIA PLANS AND  
10 FLEXIBLE SPENDING ARRANGEMENTS.—Paragraph  
11 (1) shall not apply to coverage under a long-term  
12 care insurance contract (as so defined) which is pro-  
13 vided through a cafeteria plan (as defined in section  
14 125(c)) or flexible spending or similar arrange-  
15 ment.”.

16 **SEC. 8103. QUALIFIED LONG-TERM SERVICES TREATED AS**  
17 **MEDICAL CARE.**

18 (a) GENERAL RULE.—Paragraph (1) of section  
19 213(d) of the Internal Revenue Code of 1986 (defining  
20 medical care) is amended by striking “or” at the end of  
21 subparagraph (B), by redesignating subparagraph (C) as  
22 subparagraph (D), and by inserting after subparagraph  
23 (B) the following new subparagraph:

24 “(C) for qualified long-term care services  
25 (as defined in section 818A(c)), or”.

1       (b) DEDUCTION FOR LONG-TERM CARE EXPENSES  
2 FOR PARENT OR GRANDPARENT.—Section 213 of such  
3 Code (relating to deduction for medical expenses) is  
4 amended by adding at the end the following new sub-  
5 section:

6       “(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE  
7 EXPENSES.—For purposes of subsection (a), the term ‘de-  
8 pendent’ shall include any parent or grandparent of the  
9 taxpayer for whom the taxpayer has expenses for long-  
10 term care services described in section 818A(c), but only  
11 to the extent of such expenses.”

12       (c) TECHNICAL AMENDMENTS.—

13           (1) Subparagraph (D) of section 213(d)(1) of  
14 such Code (as redesignated by subsection (a)) is  
15 amended by striking “subparagraphs (A) and (B)”  
16 and inserting “subparagraphs (A), (B), and (C)”.

17           (2)(A) Paragraph (1) of section 213(d) of such  
18 Code is amended by adding at the end thereof the  
19 following new flush sentence:

20       “In the case of a long-term care insurance contract  
21 (as defined in section 818A), only eligible long-term  
22 care premiums (as defined in paragraph (10)) shall  
23 be taken into account under subparagraph (D).”

24           (B) Subsection (d) of section 213 is amended  
25 by adding at the end the following new paragraph:

1           “(10) ELIGIBLE LONG-TERM CARE PRE-  
2 MIUMS.—

3           “(A) IN GENERAL.—For purposes of this  
4 section, the term ‘eligible long-term care pre-  
5 miums’ means the amount paid during a tax-  
6 able year for any long-term care insurance con-  
7 tract (as defined in section 818A) covering an  
8 individual, to the extent such amount does not  
9 exceed the limitation determined under the fol-  
10 lowing table:

<b>“In the case of an individual with an attained age before the close of the taxable year of:</b>	<b>The limitation is:</b>
40 or less .....	\$200
More than 40 but not more than 50 .....	375
More than 50 but not more than 60 .....	750
More than 60 but not more than 70 .....	1,600
More than 70 .....	2,000.

11           “(B) INDEXING.—

12           “(i) IN GENERAL.—In the case of any  
13 taxable year beginning in a calendar year  
14 after 1993, each dollar amount contained  
15 in paragraph (1) shall be increased by the  
16 medical care cost adjustment of such  
17 amount for such calendar year. If any in-  
18 crease determined under the preceding sen-  
19 tence is not a multiple of \$10, such in-  
20 crease shall be rounded to the nearest mul-  
21 tiple of \$10.

1           “(ii) MEDICAL CARE COST ADJUST-  
2           MENT.—For purposes of clause (i), the  
3           medical care cost adjustment for any cal-  
4           endar year is the percentage (if any) by  
5           which—

6                       “(I) the medical care component  
7                       of the Consumer Price Index (as de-  
8                       fined in section 1(f)(5)) for August of  
9                       the preceding calendar year, exceeds

10                      “(II) such component for August  
11                      of 1991.”

12           (3) Paragraph (6) of section 213(d) of such  
13           Code is amended—

14                       (A) by striking “subparagraphs (A) and  
15                       (B)” and inserting “subparagraphs (A), (B),  
16                       and (C)”, and

17                       (B) by striking “paragraph (1)(C)” in sub-  
18                       paragraph (A) and inserting “paragraph  
19                       (1)(D)”.

20           (4) Paragraph (7) of section 213(d) of such  
21           Code is amended by striking “subparagraphs (A)  
22           and (B)” and inserting “subparagraphs (A), (B),  
23           and (C)”.



1 **SEC. 8104. EXCLUSION FROM GROSS INCOME FOR**  
2 **AMOUNTS OTHERWISE INCLUDIBLE ON THE**  
3 **SURRENDER OR CANCELLATION OF ANY LIFE**  
4 **INSURANCE POLICY WHICH ARE USED FOR**  
5 **LONG-TERM CARE INSURANCE PREMIUMS.**

6 (a) IN GENERAL.—Part III of subchapter B of chap-  
7 ter 1 of the Internal Revenue Code of 1986 (relating to  
8 items specifically excluded from gross income) is amended  
9 by redesignating section 137 as section 138 and by insert-  
10 ing after section 136 the following new section:

11 **“SEC. 137. AMOUNTS RECEIVED ON CANCELLATION, ETC.,**  
12 **OF LIFE INSURANCE CONTRACTS AND USED**  
13 **TO PAY PREMIUMS FOR QUALIFIED LONG-**  
14 **TERM CARE INSURANCE.**

15 “No amount which would (but for this section) be in-  
16 cludible in the gross income of an individual shall be in-  
17 cluded in gross income on the whole or partial surrender,  
18 cancellation, or exchange of any life insurance contract  
19 during the taxable year if—

20 “(1) such individual has attained age 65 on or  
21 before the date of the transaction, and

22 “(2) the amount otherwise includible in gross  
23 income is used during such year to pay premiums  
24 for any qualified long-term care insurance policy (as  
25 defined in section 2721(a) of the Public Health  
26 Service Act) for the benefit of such individual or the

1 spouse of such individual if such spouse has attained  
2 age 65 on or before the date of the transaction.”.

3 (b) CLERICAL AMENDMENT.—The table of sections  
4 for such part III is amended by striking the last item and  
5 inserting the following new items:

“Sec. 137. Amounts received on cancellation, etc., of life insurance contracts and used to pay premiums for qualified long-term care insurance.

“Sec. 138. Cross references to other Acts.”.

6 **SEC. 8105. EFFECTIVE DATE.**

7 (a) IN GENERAL.—The amendments made by this  
8 subtitle shall apply to taxable years beginning after De-  
9 cember 31, 1995.

10 (b) TRANSITION RULE.—If, after the date of enact-  
11 ment of this Act and before January 1, 1996, a contract  
12 providing for long-term care insurance coverage is ex-  
13 changed solely for a long-term care insurance contract, no  
14 gain or loss shall be recognized on the exchange. If, in  
15 addition to a long-term care insurance contract, money or  
16 other property is received in the exchange, then any gain  
17 shall be recognized to the extent of the sum of the money  
18 and the fair market value of the other property received.  
19 For purposes of this subsection, the cancellation of a con-  
20 tract providing for long-term care insurance coverage and  
21 reinvestment of the cancellation proceeds in a long-term  
22 care insurance contract within 60 days thereafter shall be  
23 treated as an exchange. For purposes of this subsection,

1 the term “long-term care insurance contract” has the  
2 meaning given to such term by section 818A(b) of the In-  
3 ternal Revenue Code of 1986.

4 (c) ISSUANCE OF RIDER NOT TREATED AS MATE-  
5 RIAL CHANGE.—For purposes of applying sections 101(f),  
6 7702, and 7702A of the Internal Revenue Code of 1986  
7 to any contract, the issuance of a rider on a life insurance  
8 contract providing long-term care insurance coverage shall  
9 not be treated as a modification or material change of  
10 such contract.

## 11 **Subtitle C—Studies**

### 12 **SEC. 8201. FEASIBILITY OF ENCOURAGING HEALTH CARE** 13 **PROVIDERS TO DONATE SERVICES TO HOME-** 14 **BOUND PATIENTS.**

15 The Comptroller General of the United States shall  
16 conduct a study on the feasibility of encouraging health  
17 care providers to donate their services to homebound pa-  
18 tients. Such study shall include an examination of the ef-  
19 fects of qualifying such services as a charitable contribu-  
20 tion.

### 21 **SEC. 8202. FEASIBILITY OF TAX CREDIT FOR HEADS OF** 22 **HOUSEHOLDS WHO CARE FOR ELDERLY FAM-** 23 **ILY MEMBERS IN THEIR HOMES.**

24 The Comptroller General of the United States shall  
25 conduct a study on the feasibility of providing heads of

1 households who care for elderly family members in their  
2 homes with a tax credit. Such study shall estimate the  
3 cost of such a tax credit which would apply to expenses  
4 incurred in the custodial care of such an elderly family  
5 member to the extent such expenses exceed 5 percent of  
6 adjusted gross income.

7 **SEC. 8203. CASE MANAGEMENT OF CURRENT LONG-TERM**  
8 **CARE BENEFITS.**

9 (a) IN GENERAL.—The Secretary of Health and  
10 Human Services shall conduct a study of the feasibility  
11 of encouraging or requiring the use of a single designated  
12 public or nonprofit agency (such as an area agency on  
13 aging) to coordinate, through case management, the provi-  
14 sion of long-term care benefits under current Federal,  
15 State, and local programs in a geographic area.

16 (b) REPORT.—The Secretary shall submit to Con-  
17 gress a report on the study conducted under subsection  
18 (a) by not later than 1 year after the date of the enact-  
19 ment of this Act. Such report shall include such rec-  
20 ommendations regarding changes in legislation to encour-  
21 age or require the use (described in subsection (a)) of an  
22 agency to coordinate long-term care benefits as may be  
23 appropriate.

1 **SEC. 8204. SUBACUTE CARE STUDY.**

2 (a) STUDY.—The Secretary of Health and Human  
3 Services shall—

4 (1) define the level and type of care that should  
5 constitute subacute care;

6 (2) determine the appropriateness of furnishing  
7 subacute care in different settings by evaluating the  
8 quality of care and patient outcomes;

9 (3) determine the cost and effectiveness of pro-  
10 viding subacute care under the medicare program  
11 under title XVIII of the Social Security Act to indi-  
12 viduals who are eligible for benefits under part A of  
13 such title;

14 (4) determine the extent to which hospital DRG  
15 prospective payment rates under section 1886(d) of  
16 such Act (42 U.S.C. 1395ww(d)) are appropriate for  
17 the less restrictive institutional settings that provide  
18 subacute care; and

19 (5) study the relationships between institutions  
20 and their payment methodologies in order to develop  
21 ways in which to maximize the continuity of care for  
22 each patient episode in which subacute care is fur-  
23 nished.

24 (b) REPORT.—Not later than October 1, 1996, the  
25 Secretary shall submit to the Congress a report on the  
26 matters described in subsection (a).

1 **SEC. 8205. STUDY OF LONG-TERM CARE INSURANCE.**

2 (a) REPORT.—Not later than one year after the date  
 3 of enactment of this Act, the Secretary of Health and  
 4 Human Services shall report to Congress on alternatives  
 5 for extending access to long-term care through the private  
 6 insurance market. The Secretary shall specifically study  
 7 the cost of current policies, their effectiveness in providing  
 8 care and their availability to the general population.

9 (b) RECOMMENDATIONS.—The Secretary shall rec-  
 10 ommend any changes in Federal law which may be nec-  
 11 essary to increase access to long-term care for all Ameri-  
 12 cans through the private insurance market. In conducting  
 13 this study, the Secretary shall consult with the National  
 14 Association of Insurance Commissioners and other private  
 15 entities with expertise in private health insurance and  
 16 long-term care.

17 **TITLE IX—DEPARTMENT OF**  
 18 **VETERANS AFFAIRS**

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Sec. 9008. Legislative proposal on VA health coverage for medicare beneficiaries.

Sec. 9009. Outpatient clinic pilot program.

1 **SEC. 9001. BENEFITS AND ELIGIBILITY THROUGH DEPART-**  
 2 **MENT OF VETERANS AFFAIRS MEDICAL SYS-**  
 3 **TEM.**

4 (a) DVA AS A PARTICIPANT IN HEALTH CARE RE-  
 5 FORM.—

1           (1) IN GENERAL.—Title 38, United States  
2       Code, is amended by inserting after chapter 17 the  
3       following new chapter:

4       **“CHAPTER 18—ELIGIBILITY AND BENE-**  
5       **FITS UNDER ENROLLMENT-BASED**  
6       **SYSTEM**

                  “SUBCHAPTER I—GENERAL

“1801. Definitions.

                  “SUBCHAPTER II—ENROLLMENT

“1811. Enrollment: veterans.

“1812. Enrollment: CHAMPVA eligibles.

“1813. Enrollment: family members.

“1814. Enrollment ceilings.

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“1821. Benefits for VA enrollees.

“1822. Chapter 17 benefits.

“1823. Supplemental benefits packages and policies.

“1824. Limitation regarding veterans who elect not to enroll with a VA health  
                  plan.

                  “SUBCHAPTER IV—FINANCIAL MATTERS

“1831. Premiums, copayments, etc.

“1832. Medicare coverage and reimbursement.

“1833. Recovery of cost of certain care and services.

“1834. Health Plan Fund.

“1835. Guaranteed funding of Government costs

7           “SUBCHAPTER I—GENERAL

8       **“§ 1801. Definitions**

9       “For purposes of this chapter:

10       “(1) The term ‘qualified health coverage’ has  
11       the meaning given such term in section 1101 of the  
12       Bipartisan Health Care Reform Act of 1994.



1           “(2) The term ‘VA health coverage’ means  
2           qualified health coverage provided by the Secretary  
3           under section 7341 of this title.

4           “(3) The term ‘VA enrollee’ means an individ-  
5           ual enrolled under subchapter II of this chapter with  
6           VA health coverage.

7           “(4) The term ‘standard coverage’ has the  
8           meaning given such term in section 1102 of the Bi-  
9           partisan Health Care Reform Act of 1994.

10           “SUBCHAPTER II—ENROLLMENT

11   **“§ 1811. Enrollment: veterans**

12           “Subject to section 1814, each veteran residing in the  
13   United States may enroll to obtain VA health coverage.  
14   A veteran who wants to receive the standard coverage  
15   through the Department shall enroll to obtain VA health  
16   coverage.

17   **“§ 1812. Enrollment: CHAMPVA eligibles**

18           “(a) ELIGIBILITY.—Subject to section 1814, an indi-  
19   vidual described in subsection (b) who resides in the Unit-  
20   ed States may enroll to obtain VA health coverage.

21           “(b) APPLICABILITY.—This section applies to the fol-  
22   lowing individuals who are not otherwise eligible for medi-  
23   cal care under chapter 55 of title 10 (CHAMPUS):

24           “(1) The surviving spouse or child of a veteran  
25   who (A) died as a result of a service-connected dis-

1 ability, or (B) at the time of death had a total dis-  
2 ability permanent in nature, resulting from a serv-  
3 ice-connected disability.

4 “(2) The surviving spouse or child of a person  
5 who died in the active military, naval, or air service  
6 in the line of duty and not due to such person’s own  
7 misconduct.

8 “(c) DEFINITION OF CHILD.—For purposes of this  
9 section, the term ‘child’ includes a child described in sec-  
10 tion 1901(2)(B) of the Bipartisan Health Care Reform  
11 Act of 1994.

12 **“§ 1813. Enrollment: family members**

13 “(a) ELIGIBILITY.—Subject to section 1814, mem-  
14 bers of the family of an enrollee under section 1811 or  
15 1812 of this title may enroll to obtain VA health coverage.  
16 The enrollee shall have the option of enrolling to obtain  
17 VA health coverage as an individual or with family mem-  
18 bers. If the enrollee chooses to enroll to obtain VA health  
19 coverage with family members, all such family members  
20 must be so enrolled.

21 “(b) REQUIRED PAYMENTS.—Any family member  
22 with VA health coverage shall (except as provided in sec-  
23 tion 1831(c)(2)(B) of this title) be subject to payment of  
24 premiums, deductibles, copayments, and coinsurance in

1 accordance with the Bipartisan Health Care Reform Act  
2 of 1994.

3 “(c) ENROLLMENT ELIGIBILITY TO SURVIVE DEATH  
4 OF VETERAN.—An individual with VA health coverage  
5 pursuant to subsection (a) as a member of the family of  
6 a veteran enrolled under section 1811 of this title shall  
7 not lose eligibility to obtain such coverage by reason of  
8 the death of that veteran.

9 “(d) MEMBERS OF FAMILY.—For purposes of this  
10 section, the members of the family of an enrollee are those  
11 individuals (other than the enrollee) included as family  
12 members under section 1901(2) of the Bipartisan Health  
13 Care Reform Act of 1994.

14 **“§ 1814. Enrollment ceilings**

15 “(a) The Secretary shall limit the number of individ-  
16 uals eligible to enroll for VA health coverage by establish-  
17 ing and applying enrollment ceilings in accordance with  
18 this section.

19 “(b) The Secretary shall establish separate enroll-  
20 ment ceilings under subsection (a) applicable to individ-  
21 uals described in subsections (b), (c)(1), and (c)(2), re-  
22 spectively, of section 1831 of this title. The Secretary shall  
23 set such enrollment ceilings for each applicable enrollment  
24 period at levels that, when multiplied by an estimate  
25 (based on prior Department experience) of the cost to the

1 Secretary of providing the items and services in standard  
2 coverage under the Bipartisan Health Care Reform Act  
3 of 1994, would (1) result in a total cost that can be accom-  
4 modated within the appropriation available for this pur-  
5 pose in each fiscal year, and (2) avoid any need for the  
6 Secretary to take actions described in section 1821(b) of  
7 this title.

8 “(c) In establishing and managing enrollment ceilings  
9 under this section applicable to individuals described in  
10 section 1831(b), the Secretary shall establish and imple-  
11 ment priorities for enrollment consistent with priorities in  
12 chapter 17 of this title in effect on the day preceding the  
13 date of the enactment of the Bipartisan Health Care Re-  
14 form Act of 1994.

15 “SUBCHAPTER III—BENEFITS

16 “§ 1821. Benefits for VA enrollees

17 “(a) To the extent that such items and services can  
18 be provided consistent with appropriations for that pur-  
19 pose, the Secretary shall ensure that each individual en-  
20 rolled with VA health coverage is provided the items and  
21 services in standard coverage under the Bipartisan Health  
22 Care Reform Act of 1994 which the Secretary determines  
23 are clinically necessary for such individual.

24 “(b) In the event that the Secretary determines at  
25 any time during a fiscal year that appropriations are in-

1 sufficient to provide individuals enrolled with VA health  
2 coverage all needed items and services in standard cov-  
3 erage under the Bipartisan Health Care Reform Act of  
4 1994, the Secretary shall take appropriate action to limit  
5 expenditures to the amount appropriated. Such actions  
6 may include revising the scope of coverage described in  
7 subsection (a). At least 15 days before taking an action  
8 under this subsection, the Secretary shall submit to the  
9 Committees on Veterans Affairs of the House of Rep-  
10 resentatives and the Senate a report describing such pro-  
11 posed action and the circumstances requiring the Sec-  
12 retary to take such proposed action.

13 **“§ 1822. Chapter 17 benefits**

14       “(a) CARE AND SERVICES NOT INCLUDED IN STAND-  
15 ARD COVERAGE.—In the case of care and services that  
16 may be provided under chapter 17 of this title that are  
17 not included in standard coverage, the Secretary shall pro-  
18 vide to any veteran (whether or not enrolled with qualified  
19 health coverage) the care and services authorized under  
20 that chapter in accordance with the terms and conditions  
21 applicable to that veteran and that care under that chap-  
22 ter.

23       “(b) VETERANS WHO ARE NOT ELIGIBLE TO EN-  
24 ROLL UNDER THE BIPARTISAN HEALTH CARE REFORM  
25 ACT OF 1994.—In the case of a veteran who is not eligible

1 for enrollment under this chapter, the Secretary shall pro-  
2 vide to the veteran the care and services that may be pro-  
3 vided under chapter 17 of this title through any facility  
4 of the department, whether or not the facility is operating  
5 pursuant to VA health coverage.

6       “(c) PRESERVATION OF SPECIALIZED DVA TREAT-  
7 MENT CAPACITIES.—In carrying out subsection (a), the  
8 Secretary shall ensure that the Department maintains the  
9 capacity to provide for the specialized treatment and reha-  
10 bilitative needs of disabled veterans (including veterans  
11 with spinal cord dysfunction, blindness, and mental ill-  
12 ness) within distinct programs or facilities of the Depart-  
13 ment that are dedicated to the specialized needs of those  
14 veterans in a manner that affords those veterans reason-  
15 able access to care and services for those specialized needs.  
16 The Secretary shall ensure that overall capacity of the De-  
17 partment to provide such specialized services is not re-  
18 duced below the capacity of the Department, nationwide,  
19 to provide those services, as of the date of the enactment  
20 of this chapter. Nothing in this subsection precludes the  
21 Secretary from expanding the number or type of facilities  
22 or programs that provide treatment and rehabilitation  
23 services for the specialized needs of such veterans, includ-  
24 ing provision of specialized services on an outpatient basis.

1       “(d) ANNUAL REPORT.—Not later than March 1 of  
2 each year, the Secretary shall submit to the Committees  
3 on Veterans’ Affairs of the Senate and House of Rep-  
4 resentatives a report describing the actions the Secretary  
5 has taken to carry out subsection (c) during the preceding  
6 fiscal year. Each such report shall include a statement of  
7 the number of veterans to whom the Department provided  
8 specialized services that are covered by the report and the  
9 expense of providing those services, and a description of  
10 the alternatives available in the private sector for the pro-  
11 vision of those services to veterans.

12       **“§ 1823. Supplemental benefits packages and policies**

13       “Subject to section 1814, VA health coverage may  
14 include supplemental health benefits packages and supple-  
15 mental cost sharing policies consistent with the Bipartisan  
16 Health Care Reform Act of 1994. However, such coverage  
17 may not include a supplemental health benefits package  
18 to a veteran that provides coverage for services that the  
19 Department is required to provide to that veteran under  
20 chapter 17 of this title.

21       **“§ 1824. Limitation regarding veterans who elect not**  
22                               **to enroll to obtain VA health coverage**

23       “(a) REIMBURSEMENT REQUIRED.—A veteran who is  
24 residing in an area in which the Department offers VA  
25 health coverage and who elects not to enroll to obtain such

1 coverage may be provided the items and services in stand-  
2 ard coverage through VA health coverage offered in that  
3 area only if (except as provided in subsection (b)) the Sec-  
4 retary is reimbursed for the cost of the care provided.

5 “(b) EXCEPTION.—The Secretary may not impose on  
6 or collect from a veteran described in subsection (a) a cost-  
7 share charge of any kind in the case of treatment for a  
8 service-connected disability that (as determined by the  
9 Secretary) requires a specialized treatment capacity for  
10 which the Department has particular expertise.

11 **“§ 1825. Limitation on use of funds for abortions**

12 “None of the funds appropriated to carry out this  
13 title shall be expended for any abortion except when it is  
14 made known to the Secretary that such procedure is nec-  
15 essary to save the life of the mother or that the pregnancy  
16 is the result of an act of rape or incest.

17 **“SUBCHAPTER IV—FINANCIAL MATTERS**

18 **“§ 1831. Premiums, copayments, etc.**

19 “(a) EXEMPTION OF CERTAIN VETERANS.—Subject  
20 to subsection (f), in the case of a veteran described in sub-  
21 section (b) who is a VA enrollee, there may not be imposed  
22 or collected from the veteran a cost-share charge of any  
23 kind (whether a premium, copayment, deductible, coinsur-  
24 ance charge, or other charge) for items and services in



1 standard coverage that are provided to the veteran by the  
2 Secretary within a VA plan provider network.

3 “(b) VETERANS EXEMPT FROM CHARGES.—The vet-  
4 erans referred to in subsection (a) are the following:

5 “(1) Any veteran with a service-connected dis-  
6 ability rated at 10 percent or greater.

7 “(2) Any veteran whose discharge or release  
8 from the active military, naval or air service was for  
9 a disability incurred or aggravated in the line of  
10 duty.

11 “(3) Any veteran who is in receipt of, or who,  
12 but for a suspension pursuant to section 1151 of  
13 this title (or both such a suspension and the receipt  
14 of retired pay), would be entitled to disability com-  
15 pensation, but only to the extent that such a veter-  
16 an’s continuing eligibility for such care is provided  
17 for in the judgment or settlement provided for in  
18 such section.

19 “(4) Any veteran who is a former prisoner of  
20 war.

21 “(5) Any veteran of the Mexican border period  
22 or World War I.

23 “(6) Any veteran who is unable to defray the  
24 expenses of necessary care as determined under sec-  
25 tion 1722(a) of this title.

1       “(c) OTHER ENROLLEES.—(1) In the case of a VA  
2 enrollee who is not described in subsection (b), the Sec-  
3 retary shall (except as provided in paragraph (2)) charge  
4 premiums and shall establish copayments, deductibles, and  
5 coinsurance amounts.

6       “(2) The Secretary may not collect from an enrollee  
7 a premium in the case of—

8               “(A) an individual with VA health coverage by  
9 reason of eligibility under section 1812 of this title;  
10 or

11              “(B) an individual with VA health coverage by  
12 reason of eligibility under section 1813 of this title  
13 and who is described in paragraph (1) of section  
14 1713(a) of this title.

15       “(3) The Secretary may not charge a copayment, de-  
16 ductible, or other coinsurance amount in the case of care  
17 for any disease covered under section 1710(e)(1) of this  
18 title.

19       “(d) ESTABLISHMENT OF RATES.—The premium  
20 rate, and the rates for deductibles and copayments, appli-  
21 cable under VA health coverage shall be established by the  
22 Secretary based on rules applicable to all health coverage  
23 offered in the geographic area in which such VA health  
24 coverage is offered.

1       “(e) DUTIES OF EMPLOYERS.—The obligations (in-  
2 cluding obligations with respect to payment of premiums)  
3 under the Bipartisan Health Care Reform Act of 1994  
4 of an employer with respect to employees with VA health  
5 coverage, and with respect to such coverage, shall be the  
6 same as those that apply with respect to other employees  
7 and other health coverage.

8       “(f) ACCEPTANCE OF PREMIUM CERTIFICATES.—In  
9 the case of a veteran who has been issued a premium cer-  
10 tificate or voucher under the Bipartisan Health Care Re-  
11 form Act of 1994, the Secretary may require the veteran  
12 to tender the certificate to the Secretary as a condition  
13 of enrollment and the Secretary may accept the certificate.

14       **“§ 1832. Recovery of cost of certain care and services**

15       “(a) RECOVERY FROM THIRD PARTIES.—In the case  
16 of an individual provided care or services through VA  
17 health coverage who has coverage under any supplemental  
18 health insurance policy, including a Medicare supple-  
19 mental health insurance plan, the Secretary has the right  
20 to recover or collect charges for care or services (as deter-  
21 mined by the Secretary, but not including care or services  
22 for a service-connected disability) from the party providing  
23 that coverage to the extent that the individual (or the pro-  
24 vider of the care or services) would be eligible to receive  
25 payment for such care or services from such party if the

1 care or services had not been furnished by a department  
2 or agency of the United States.

3 “(b) PROCEDURES.—The provisions of subsections  
4 (b) through (f) of section 1729 of this title shall apply  
5 with respect to claims by the United States under sub-  
6 section (a) in the same manner as they apply to claims  
7 under subsection (a) of that section.

8 **“§ 1833. Health Coverage Fund**

9 “(a) ESTABLISHMENT OF FUND.—There is hereby  
10 established in the Treasury a revolving fund to be known  
11 as the ‘Department of Veterans Affairs Health Coverage  
12 Fund’.

13 “(b) CREDITING OF AMOUNTS TO FUND.—There  
14 shall be credited to the revolving fund any amount received  
15 by the Department by reason of the furnishing of health  
16 care under VA health coverage and any amount received  
17 by the Department by reason of the enrollment of an indi-  
18 vidual with VA health coverage (including amounts re-  
19 ceived as premiums, premium certificates or vouchers,  
20 copayments or coinsurance, and deductibles), any amount  
21 received as a third-party reimbursement, and any amount  
22 received as a reimbursement from other health coverage  
23 for care furnished to one of its enrollees.

24 “(c) CREDITING TO TREASURY.—Any amounts de-  
25 posited to the revolving fund that are attributable to

1 amounts received by the Department as a premium, in-  
2 cluding a premium certificate or voucher, by reason of the  
3 enrollment with VA health coverage of a veteran described  
4 in section 1831(b) of this title shall be covered into the  
5 General Fund of the Treasury.

6 “(d) AMOUNTS NOT PERMITTED TO BE RE-  
7 TAINED.—Notwithstanding subsection (b), the Depart-  
8 ment may not retain amounts received for care furnished  
9 to a VA enrollee in a case in which the costs of such care  
10 have been covered by appropriations. Such amounts shall  
11 be deposited in the General Fund of the Treasury.

12 “(e) AVAILABILITY OF FUNDS.—Amounts in the re-  
13 volving fund are hereby made available for all expenses,  
14 both direct and indirect, related to the delivery through  
15 VA health coverage of the items and services in standard  
16 coverage and any supplemental benefits package or policy  
17 offered through such coverage.”.

18 (b) PRESERVATION OF EXISTING BENEFITS FOR FA-  
19 CILITIES NOT OFFERING SERVICES THROUGH QUALIFIED  
20 HEALTH COVERAGE.—(1) Chapter 17 of title 38, United  
21 States Code, is amended by inserting after section 1704  
22 the following new section:

1 **“§ 1705. Facilities not offering qualified health cov-**  
2 **erage; veterans not eligible to enroll to**  
3 **obtain coverage**

4 “The provisions of this chapter shall apply with re-  
5 spect to the furnishing of care and services—

6 “(1) by any facility of the Department that (A)  
7 is not offering qualified health coverage under the  
8 Bipartisan Health Care Reform Act of 1994, and  
9 (B) is not located in a State (or portion of a State)  
10 that is a single payer area; and

11 “(2) by any facility of the Department (whether  
12 or not offering qualified health coverage under the  
13 Bipartisan Health Care Reform Act of 1994) in the  
14 case of a veteran who is not eligible for enrollment  
15 under chapter 18 of this title.”.

16 (2) The table of sections at the beginning of such  
17 chapter is amended by inserting after the item relating  
18 to section 1704 the following new item:

“1705. Facilities not offering qualified health coverage; veterans not eligible to  
enroll to obtain coverage.”.

19 **SEC. 9002. ORGANIZATION OF DEPARTMENT OF VETERANS**  
20 **AFFAIRS FACILITIES AS FACILITIES OFFER-**  
21 **ING QUALIFIED HEALTH COVERAGE.**

22 (a) IN GENERAL.—Chapter 73 of title 38, United  
23 States Code, is amended—

1           (1) by redesignating subchapter IV as sub-  
2       chapter V; and

3           (2) by inserting after subchapter III the follow-  
4       ing new subchapter:

5       “SUBCHAPTER IV—PARTICIPATION AS PART OF  
6       NATIONAL HEALTH CARE REFORM

7       **“§ 7341. Organization of health care facilities as fa-**  
8       **cilities offering qualified health coverage**

9       “(a) Except as provided in section 7342 of this title,  
10     the Secretary may, subject to the availability of appropria-  
11     tions, organize Department plans and facilities as entities  
12     and facilities offering qualified health coverage under the  
13     Bipartisan Health Care Reform Act of 1994 subject to  
14     adjustment under subsection (g). The Secretary shall pre-  
15     scribe regulations establishing standards for the operation  
16     of Department health care facilities as facilities offering  
17     qualified health coverage under the Bipartisan Health  
18     Care Reform Act of 1994. In prescribing those standards,  
19     the Secretary shall assure that they conform, to the maxi-  
20     mum extent practicable, to the requirements for qualified  
21     health coverage generally set forth in the Bipartisan  
22     Health Care Reform Act of 1994.

23       “(b) Within a geographic area or region, health care  
24     facilities of the Department located within that area or  
25     region may be organized to operate as a single entity offer-

1 ing qualified health coverage encompassing all Depart-  
2 ment facilities within that area or region or may be orga-  
3 nized to operate as several entities offering qualified  
4 health coverage.

5 “(c) A health plan purchasing organization operating  
6 within one or more fair rating areas shall offer as an op-  
7 tion to eligible individuals enrollment to obtain VA health  
8 coverage that is offered in such area.

9 “(d) Any health insurance program that is provided  
10 for Federal employees shall include enrollment to obtain  
11 VA health coverage as enrollment options for eligible indi-  
12 viduals. Premiums shall be paid for VA health coverage  
13 under any such insurance program based upon enrollment  
14 with that program in the same manner as to any other  
15 health coverage.

16 “(e)(1) In establishing and operating standard health  
17 coverage, the Secretary, in consultation with the Comp-  
18 troller General, shall take appropriate steps to ensure the  
19 financial solvency and stability of the VA health coverage  
20 and of contractors and subcontractors providing services  
21 pursuant to section 7343 of this title.

22 “(2) In carrying out paragraph (1), the Secretary  
23 may purchase from commercial sources insurance to in-  
24 sure the Department against the financial risks involved  
25 in the offering of VA health coverage.



1       “(3) Notwithstanding any other provision of law,  
2 there shall be no requirements applicable to the offering  
3 of VA health coverage with respect to the maintenance of  
4 a reserve fund, requirements to reinsure, or payments into  
5 any other financial integrity fund other than as estab-  
6 lished pursuant to paragraph (1).

7       “(f) In carrying out responsibilities under the Bipar-  
8 tisan Health Care Reform Act of 1994, a State (or a  
9 State-established entity)—

10           “(1) may not impose any standard or require-  
11 ment on VA health coverage that is inconsistent with  
12 this section or any regulation prescribed under this  
13 section or other Federal laws regarding the oper-  
14 ation of this section; and

15           “(2) may not deny certification of VA health  
16 coverage under the Bipartisan Health Care Reform  
17 Act of 1994 on the basis of a conflict between a rule  
18 of a State (or State-established entity) and this sec-  
19 tion or regulations prescribed under this section or  
20 other Federal laws regarding the operation of this  
21 section.

22       “(g) Notwithstanding any provision of the Bipartisan  
23 Health Care Reform Act of 1994 or this subchapter, any  
24 reference in this subchapter to ‘qualified health coverage’  
25 under such Act shall, subject to section 1821(b) of this

1 title, be considered a reference to coverage of a standard-  
2 ized package of benefits established by the Secretary with  
3 an actuarial value not less than the actuarial value of  
4 qualified health coverage under such Act.

5 **“§ 7342. Operation of health care facilities within**  
6 **States operating as single payer areas**

7 “(a) In a State (or portion of a State) that operates  
8 as a single payer system, Department health care facilities  
9 in that State (or portion of a State) shall serve as provid-  
10 ers to individuals residing in that State (or portion of a  
11 State) who would be eligible to enroll under chapter 18  
12 of this title to obtain VA health coverage if they were re-  
13 siding in an area where qualified health coverage was of-  
14 fered under the Bipartisan Health Care Reform Act of  
15 1994. Such facilities may provide those individuals any  
16 covered service in standard coverage.

17 “(b) A Department facility providing care to resi-  
18 dents of a single payer area pursuant to subsection (a)  
19 shall be reimbursed for that care on the same basis as  
20 any other provider furnishing the same services in that  
21 area.

22 “(c) A veteran described in section 1831(b) of this  
23 title shall be exempt from any otherwise applicable charges  
24 for such care. Any other individual provided care pursuant  
25 to subsection (a) shall be subject to all applicable require-

1 ments respecting copayments, deductibles, and coinsur-  
2 ance. Notwithstanding the preceding sentence, section  
3 1831(c)(3) of this title shall apply to any such charge.

4 **“§ 7343. Health care resource agreements**

5 “(a)(1) In accordance with policies established under  
6 subsection (b), an official specified in paragraph (2) may,  
7 without regard to any law or regulation specified in para-  
8 graph (3), enter into agreements with health care plans,  
9 with insurers, and with health care providers, and with  
10 any other entity or individual, to furnish or obtain any  
11 health-care resource.

12 “(2) An official specified in this paragraph is any of  
13 the following:

14 “(A) The head official offering VA health cov-  
15 erage.

16 “(B) The director of a Department health care  
17 facility that is providing service through VA health  
18 coverage.

19 “(C) The director of a Department health care  
20 facility that is operating in a State (or portion of a  
21 State) that is operating under a single payer system.

22 “(3) A law or regulation specified in this paragraph  
23 is any of the following:

24 “(A) Section 1703 of this title.

1           “(B) Any other law or regulation pertaining  
2       to—

3                   “(i) competitive procedures;

4                   “(ii) acquisition procedures or policies  
5               (other than contract dispute settlement proce-  
6               dures); or

7                   “(iii) bid protests.

8       “(4) For purposes of this subsection, the term  
9       ‘health-care resource’ has the meaning given that term in  
10      section 8152 of this title.

11       “(b) Policies established by the Secretary under sub-  
12      section (a) shall include appropriate provisions to ensure  
13      that procurements under that subsection are carried out  
14      in a manner consistent with (1) Federal acquisition poli-  
15      cies regarding nondiscrimination, equal opportunity, busi-  
16      ness integrity, and safeguarding against fraud and abuse,  
17      and (2) the goal of a streamlined process for the acquisi-  
18      tion of health-care resources.

19       “(c) Any proceeds to the Government received from  
20      an agreement under subsection (a) shall be credited to the  
21      Department of Veterans Affairs Health Coverage Fund  
22      established under section 1834 of this title and to funds  
23      that have been allotted to the facility that furnished the  
24      resource involved.

1 **“§ 7344. Administrative and personnel flexibility**

2 “(a) In order to carry out this subchapter, the Sec-  
3 retary may—

4 “(1) subject to section 1822(c) of this title,  
5 carry out administrative reorganizations of the De-  
6 partment without regard to those provisions of sec-  
7 tion 510 of this title following subsection (a) of that  
8 section; and

9 “(2) when the Secretary finds it is cost-effective  
10 or necessary in order to provide health care services  
11 in a timely manner—

12 “(A) enter into contracts for procurement  
13 of any commercially available item at a cost of  
14 under \$100,000 without regard to any provision  
15 of law or regulation (i) requiring competitive  
16 procedures; (ii) mandating or giving priority to  
17 any source of supply; or (iii) pertaining to pro-  
18 tests; and

19 “(B) enter into contracts without regard to  
20 section 8110(c) of this title for the performance  
21 of services previously performed by employees  
22 of the Department.

23 “(b)(1) The Secretary may establish alternative per-  
24 sonnel systems or procedures for personnel at facilities of-  
25 fering qualified health coverage under this title, or for per-  
26 sonnel at facilities operating in a State (or portion of a

1 State) that is operating under a single payer system,  
2 whenever the Secretary considers such action necessary,  
3 except that the Secretary shall provide for preference eligi-  
4 bles (as defined in section 2108 of title 5) in a manner  
5 comparable to the preference for such eligibles under sub-  
6 chapter I of chapter 33, and subchapter I of chapter 35,  
7 of such title.

8 “(2) In establishing alternative personnel systems or  
9 procedures under this subsection, the Secretary shall in-  
10 clude the following:

11 “(A) A system that ensures that applicants for  
12 employment and employees are appointed, promoted,  
13 and assigned on the basis of merit and fitness.

14 “(B) An equal employment opportunity pro-  
15 gram.

16 “(C) Compensation systems which will be used  
17 to set rates of pay that are competitive with rates  
18 of pay paid by health-care providers other than the  
19 Department and that take into consideration the dif-  
20 ficulty, responsibility, and qualification requirements  
21 of the work performed.

22 “(D) A formal performance appraisal system.

23 “(E) A system to address unacceptable conduct  
24 and performance by employees, including a general  
25 statement of violations, sanctions, and procedures

1       which shall be made known to all employees, and a  
2       dispute resolution procedure.

3           “(F) A formal policy regarding the accrual and  
4       use of sick leave and annual leave.

5       “(c) The Secretary may carry out appropriate pro-  
6       motional, advertising, and marketing activities to inform  
7       individuals of the availability of facilities of the Depart-  
8       ment offering qualified health coverage.

9       **“§ 7345. Veterans Health Care Transition Fund**

10       “(a) For each of fiscal years 1995 and 1996, the Sec-  
11       retary of the Treasury shall credit to a special fund (in  
12       this section referred to as the ‘Fund’) of the Treasury an  
13       amount equal to—

14           “(1) \$1,200,000,000 for fiscal year 1995; and

15           “(2) \$800,000,000 for fiscal year 1996.

16       “(b) Amounts in the Fund shall be available to the  
17       Secretary only for VA health coverage authorized under  
18       this chapter. Such amounts are available without fiscal  
19       year limitation for costs of commencing the offering of VA  
20       health coverage, including consulting services, equipment,  
21       marketing, and other costs, minor construction, and (sub-  
22       ject to section 8104 of this title) major construction.

23       “(c) The Secretary shall submit to Congress, no later  
24       than March 1, 1996, a report concerning the operation  
25       of the Department of Veterans Affairs health care system

1 in preparing for, and operating under, national health care  
2 reform under the Bipartisan Health Care Reform Act of  
3 1994 during fiscal years 1995 and 1996. The report shall  
4 include a discussion of—

5           “(1) the adequacy of amounts in the Fund for  
6           the offering of VA health coverage;

7           “(2) the quality of care provided by the Depart-  
8           ment; and

9           “(3) the ability of the Department to attract  
10          patients.

11 **“§ 7346. Funding provisions: grants and other sources**  
12 **of assistance**

13          “The Secretary may apply for and accept, if awarded,  
14 any grant or other source of funding that is intended to  
15 meet the needs of special populations and that but for this  
16 section is unavailable to facilities of the Department or  
17 to qualified health coverage offered by the Government if  
18 funds obtained through the grant or other source of fund-  
19 ing will be used through a facility of the Department offer-  
20 ing qualified health coverage.”.

21          (b) CLERICAL AMENDMENT.—The table of sections  
22 at the beginning of chapter 73 is amended by striking out  
23 the item relating to the heading for subchapter IV and  
24 inserting in lieu thereof the following:



“SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE  
REFORM

“7341. Organization of health care facilities as facilities offering qualified health coverage

“7342. Operation of health care facilities within States operating as single payer areas.

“7343. Health care resource agreements.

“7344. Administrative and personnel flexibility.

“7345. Veterans Health Coverage Transition Fund.

“7346. Funding provisions: grants and other sources of assistance.

“SUBCHAPTER V—RESEARCH CORPORATIONS”.

1 **SEC. 9003. ELIGIBILITY FOR CHAPTER 17 CARE.**

2 (a) NURSING HOME CARE.—Section 1710(a)(1) of  
3 title 38, United States Code, is amended by inserting “(or,  
4 in the case of a veteran described in subparagraph (A)  
5 or (D) below, shall furnish nursing home care)” after  
6 “may furnish nursing home care”.

7 (b) OUTPATIENT CARE FOR ENROLLED VETER-  
8 ANS.—Paragraph (1) of section 1712(a) of such title is  
9 amended—

10 (1) by striking out “and” at the end of sub-  
11 paragraph (C);

12 (2) by striking out the period at the end of sub-  
13 paragraph (D) and inserting in lieu thereof a semi-  
14 colon; and

15 (3) by adding at the end the following:

16 “(E) to any veteran described in section  
17 1831(b) of this title who is enrolled under section  
18 1811 of this title and the Bipartisan Health Care  
19 Reform Act of 1994 with VA health coverage (as de-

1       fined in section 1801 of this title), for any disability  
2       to the extent that care and treatment of that disabil-  
3       ity is not included within standard coverage (as de-  
4       fined in section 1801 of this title);”.

5       (c) OBVIATE-THE-NEED OUTPATIENT CARE.—(1)  
6       Paragraph (2) of such section is amended by striking out  
7       “The Secretary” and all that follows through “this sub-  
8       section—” and inserting in lieu thereof “Except as pro-  
9       vided in subsection (b) of this section, the Secretary shall  
10      furnish on an ambulatory or outpatient basis such medical  
11      services as the Secretary determines are needed—”.

12      (2) Paragraph (4) of such section is amended by  
13      striking out “medical services for a purpose described in  
14      paragraph (5) of this subsection” and inserting in lieu  
15      thereof “, to the extent that facilities are available, such  
16      medical services as the Secretary determines are needed”.

17      (3) Such section is further amended—

18              (A) by striking out paragraph (5); and

19              (B) by redesignating paragraphs (6) and (7) as  
20      paragraphs (5) and (6), respectively.

21      (d) CONFORMING AMENDMENTS.—(1) Section  
22      1701(6)(A)(i) of such title is amended by striking out  
23      “(except under the conditions described in section  
24      1712(a)(5)(A) of this title)”.

1       (2) Section 1701(6)(B)(i)(II) of such title is amended  
2 by striking “section 1712(a)(5)(B)” and inserting in lieu  
3 thereof “section 1712”.

4       (3) Section 1703(a)(2)(B) of such title is amended  
5 by striking out “for a purpose described in section  
6 1712(a)(5)(B) of this title” and inserting in lieu thereof  
7 “to complete treatment incident to hospital, nursing home,  
8 or domiciliary care that has been provided by the Depart-  
9 ment”.

10       (4) Section 1712A(b)(1) of such title is amended by  
11 striking out “section 1712(a)(5)(B)” and inserting in lieu  
12 thereof “section 1703(a)(2)(B)”.

13   **SEC. 9004. AUTHORITY TO PROVIDE HEALTH CARE FOR**  
14                   **HERBICIDE AND RADIATION EXPOSURE.**

15       (a) AUTHORIZED INPATIENT CARE.—Section  
16 1710(e) of title 38, United States Code, is amended to  
17 read as follows:

18       “(e)(1)(A) Subject to paragraph (4), a herbicide-ex-  
19 posed veteran is eligible for hospital care and nursing  
20 home care under subsection (a)(1)(G) for any disease  
21 specified in subparagraph (B).

22       “(B) The diseases referred to in subparagraph (A)  
23 are those for which the National Academy of Sciences, in  
24 a report issued in accordance with section 2 of the Agent  
25 Orange Act of 1991, has determined—

1           “(i) that there is sufficient evidence to conclude  
2           that there is a positive association between occur-  
3           rence of the disease in humans and exposure to a  
4           herbicide agent;

5           “(ii) that there is evidence which is suggestive  
6           of an association between occurrence of the disease  
7           in humans and exposure to a herbicide agent, but  
8           such evidence is limited in nature; or

9           “(iii) that available studies are insufficient to  
10          permit a conclusion about the presence or absence of  
11          an association between occurrence of the disease in  
12          humans and exposure to a herbicide agent.

13          “(2) A radiation-exposed veteran is eligible for hos-  
14          pital care and nursing home care under subsection  
15          (a)(1)(G) for—

16               “(A) any disease listed in section 1112(c)(2) of  
17               this title; and

18               “(B) any other disease for which the Secretary,  
19               based on the advice of the Advisory Committee on  
20               Environmental Hazards, determines that there is  
21               credible evidence of a positive association between  
22               occurrence of the disease in humans and exposure to  
23               ionizing radiation.

24          “(3) Subject to paragraph (4), a veteran who the Sec-  
25          retary finds may have been exposed while serving on active

1 duty in the Southwest Asia theater of operations during  
2 the Persian Gulf War to a toxic substance or environ-  
3 mental hazard is eligible for hospital care and nursing  
4 home care under subsection (a)(1)(G) of this section for  
5 any disability which becomes manifest before October 1,  
6 1996, notwithstanding that there is insufficient medical  
7 evidence to conclude that such disability may be associated  
8 with such exposure.

9 “(4) Hospital and nursing home care may not be pro-  
10 vided under or by virtue of paragraph (1) after September  
11 30, 1996, or, in the case of a veteran described in para-  
12 graph (3), after September 30, 1998.

13 “(5) For purposes of this subsection and section  
14 1712 of this title—

15 “(A) the term ‘herbicide-exposed veteran’  
16 means a veteran (i) who served on active duty in the  
17 Republic of Vietnam during the Vietnam era, and  
18 (ii) who the Secretary finds may have been exposed  
19 during such service to a herbicide agent;

20 “(B) the term ‘herbicide agent’ has the mean-  
21 ing given that term in section 1116(a)(4) of this  
22 title; and

23 “(C) the term ‘radiation-exposed veteran’ has  
24 the meaning given that term in section 1112(c)(4) of  
25 this title.”.

1 (b) AUTHORIZED OUTPATIENT CARE.—Section 1712  
2 of such title is amended—

3 (1) in subsection (a)(1) (as amended by section  
4 9003(b)), by adding at the end the following:

5 “(F) during the period before October 1, 1996,  
6 to any herbicide-exposed veteran for any disease list-  
7 ed in section 1710(e)(1)(B) of this title; and

8 “(G) to any radiation-exposed veteran for any  
9 disease covered under section 1710(e)(1)(C) of this  
10 title.”; and

11 (2) in subsection (i)(3)—

12 (A) by striking out “(A)”; and

13 (B) by striking out “, or (B)” and all that  
14 follows through “title”.

15 (c) SAVINGS PROVISION.—The provisions of sections  
16 1710(e) and 1712(a) of title 38, United States Code, as  
17 in effect on the day before the date of the enactment of  
18 this Act, shall apply with respect to hospital care, nursing  
19 home care, and medical services in the case of any veteran  
20 furnished care or services before such date of enactment  
21 on the basis of presumed exposure to a substance or radi-  
22 ation under the authority of those provisions.

1 **SEC. 9005. EXTENSION OF AUTHORITY TO PROVIDE PRIOR-**  
2 **ITY OUTPATIENT HEALTH CARE FOR EXPO-**  
3 **SURE TO ENVIRONMENTAL HAZARDS.**

4 Section 1712(a)(1)(D) of title 38, United States  
5 Code, is amended by striking out “December 31, 1994,  
6 for any disability” and inserting in lieu thereof “October  
7 1, 1998, for any disability which becomes manifest before  
8 October 1, 1996,”.

9 **SEC. 9006. REPORT ON WAIVING COST-SHARING FOR CER-**  
10 **TAIN MEDICAL CARE FOR DEPENDENTS OF**  
11 **PERSIAN GULF VETERANS WHO MAY HAVE**  
12 **BEEN EXPOSED TO ENVIRONMENTAL HAZ-**  
13 **ARDS.**

14 (a) REPORT.—The Secretary of Veterans Affairs  
15 shall submit to Congress a report on the desirability and  
16 the feasibility of waiving any requirement for cost-sharing  
17 in the case of medical care described in subsection (b) that  
18 is provided through VA health coverage under chapter 18  
19 of title 38, United States Code (as added by section 9001),  
20 to an individual who is a VA enrollee enrolled under fam-  
21 ily-member eligibility under section 1813 of that chapter.

22 (b) PERSIAN GULF WAR ILLNESS.—Medical care re-  
23 ferred to in subsection (a) is medical care provided to a  
24 family member of a veteran described in subparagraph (C)  
25 of section 1710(e)(1) of title 38, United States Code, for  
26 any disease or disability occurring in that family member

1 which the Secretary finds may be related to the service  
2 of the veteran in the Southwest Asia theater of operations  
3 during the Persian Gulf War.

4 (c) MATTERS TO BE CONSIDERED.—In preparing  
5 the report under subsection (a), the Secretary shall con-  
6 sider relevant studies, including those that have been (or  
7 that are being) conducted by the Department of Veterans  
8 Affairs, the Department of Defense, the National Insti-  
9 tutes of Health, the National Academy of Sciences, and  
10 private health care providers.

11 (d) SUBMISSION OF REPORT.—The report under sub-  
12 section (a) shall be submitted not later than 60 days after  
13 the date of the enactment of this Act.

14 **SEC. 9007. STUDY OF THE EFFECT OF TELEMEDICINE ON**  
15 **THE DELIVERY OF VA HEALTH CARE SERV-**  
16 **ICES.**

17 (a) IN GENERAL.—During each of fiscal years 1995  
18 through 1997, the Secretary of Veterans Affairs shall  
19 carry out a study of the effect of telemedicine on the deliv-  
20 ery, accessibility, and quality of health care services avail-  
21 able to individuals who are eligible for coverage through  
22 the Department of Veterans Affairs.

23 (b) REPORTS.—Not later than 120 days after the  
24 date of the enactment of this Act and annually thereafter  
25 through 1998, the Secretary shall submit to the Commit-



tees on Veterans' Affairs of the Senate and House of Representatives a report, including descriptions of the telemedicine applications benefiting veterans, relating to the study conducted under subsection (a).

(c) CONSULTATION.—Each study under subsection (a) shall be carried out in consultation with the Secretary of Health and Human Services, the Secretary of Defense, the Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President.

**SEC. 9008. LEGISLATIVE PROPOSAL ON VA HEALTH COVERAGE FOR MEDICARE BENEFICIARIES.**

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in consultation with the Secretary of Veterans Affairs, shall develop and submit to Congress a proposal for legislation which provides for obtaining VA health coverage for medicare beneficiaries who are veterans.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term “medicare beneficiary” means an individual who is eligible for benefits under part

1 A of title XVIII of the Social Security Act and is en-  
2 rolled under part B of such title.

3 (b) CONTENTS OF THE PROPOSAL.—A proposal for  
4 legislation submitted under subsection (a) shall—

5 (1) provide for an appropriate methodology by  
6 which the Secretary shall make payment to the Sec-  
7 retary of Veterans Affairs for the enrollment of med-  
8 icare beneficiaries;

9 (2) provide individuals the opportunity to re-  
10 main enrolled to obtain VA health coverage without  
11 an interruption in coverage upon becoming medicare  
12 beneficiaries; and

13 (3) provide medicare beneficiaries who are vet-  
14 erans with the opportunity to enroll to obtain VA  
15 health coverage as an individual or with family mem-  
16 bers.

17 **SEC. 9009. OUTPATIENT CLINIC PILOT PROGRAM.**

18 (a) PILOT PROGRAM.—The Secretary of Veterans Af-  
19 fairs shall carry out a pilot program to reduce waiting  
20 times for patients seeking health-care services in out-  
21 patient clinics of the Department of Veterans Affairs and  
22 the traveling distance to such clinics.

23 (b) ADDITIONAL CLINICS.—Under the pilot program,  
24 the Secretary shall provide for the operation of approxi-  
25 mately 20 new outpatient clinics around 2 medical centers

1 of the Department of Veterans Affairs. The Secretary  
2 shall select the locations for the clinics so that veterans  
3 served by one of the clinics would be within a one-hour  
4 drive of such a clinic.

5 (c) SERVICES.—The Secretary shall ensure that the  
6 clinics provide a wide range of services, including x-ray,  
7 laboratory, physical therapy, respiratory therapy, pharma-  
8 ceutical services, and psychological services, to be available  
9 at those clinics.

10 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
11 are authorized to be appropriated, for each of fiscal years  
12 1998 through 2004, such sums as may be necessary to  
13 carry out this section.

14 **TITLE X—MISCELLANEOUS**  
15 **SAVINGS PROVISIONS**

TABLE OF CONTENTS OF TITLE

**Subtitle A—Automobile Insurance Coordination**

- Sec. 10001. Definitions.
- Sec. 10002. Provision of automobile insurance medical services through health plans.
- Sec. 10003. Payment for automobile insurance medical services.
- Sec. 10004. Payment facilitation.
- Sec. 10005. Payment of State administrative expenses.
- Sec. 10006. Construction.

**Subtitle B—Prefunding Government Health Benefits Contributions**

- Sec. 10101. Requirement that certain agencies prefund government health benefits contributions for their annuitants.

1     **Subtitle A—Automobile Insurance**  
2                     **Coordination**

3     **SEC. 10001. DEFINITIONS.**

4         In this subtitle—

5             (1) INJURED INDIVIDUAL.—The term “injured  
6         individual” means an individual who has a bodily in-  
7         jury or illness sustained in an automobile accident  
8         and who is entitled to receive automobile insurance  
9         medical services from a health plan.

10            (2) AUTOMOBILE INSURANCE MEDICAL SERV-  
11         ICES.—The term “automobile insurance medical  
12         services” means services and items covered by auto-  
13         mobile insurance that are medically necessary or ap-  
14         propriate for treatment of bodily injuries or illnesses  
15         sustained in automobile accidents and that are with-  
16         in the scope of the benefits to which an injured indi-  
17         vidual is entitled under his or her health plan.

18            (3) AUTOMOBILE INSURANCE CARRIER.—The  
19         term “automobile insurance carrier” means an in-  
20         surance company, employer, or fund that is liable for  
21         payment for automobile insurance medical services  
22         based either on a direct contractual obligation to an  
23         injured individual or an obligation on behalf of a  
24         person responsible for causation of an injured indi-  
25         vidual’s bodily injury or illness.

1           (4) HEALTH PLAN.—The term “health plan”  
2       means a plan or organization that pays for the serv-  
3       ices of health care providers and is subject to Fed-  
4       eral or State regulation.

5   **SEC. 10002. PROVISION OF AUTOMOBILE INSURANCE MEDI-**  
6                           **CAL SERVICES THROUGH HEALTH PLANS.**

7       (a) IN GENERAL.—An individual enrolled in a health  
8       plan shall receive automobile insurance medical services  
9       exclusively through the provision (or arrangement for the  
10      provision) of such services by the health plan. Such serv-  
11      ices shall be subject to all quality, cost containment, and  
12      anti-fraud and abuse provisions that apply generally to  
13      medical services provided by or through health plans.

14      (b) ALTERNATIVE PERMITTED.—

15           (1) BY AGREEMENT.—Subsection (a) shall not  
16      prevent an individual and an automobile insurance  
17      carrier from agreeing that treatment for bodily in-  
18      jury or illness sustained in an automobile accident  
19      shall be provided other than by or through the  
20      health plan in which the individual is enrolled. No-  
21      tice of any such agreement shall be filed with the in-  
22      jured individual’s health plan. Upon receipt of such  
23      notice, the health plan shall be absolved of all re-  
24      sponsibility for payment of any services covered by  
25      the agreement.

1           (2) MEDICARE AND MEDICAID.—Subsection (a)  
2       shall not prevent a State from requiring automobile  
3       insurance carrier to make direct payment to health  
4       care providers for automobile insurance medical  
5       services that are covered both by (A) medicare or  
6       medicaid, and (B) and automobile insurance con-  
7       tract that is required by law and provides for direct  
8       payment of medical services regardless of fault. Pay-  
9       ment for automobile insurance medical services in  
10      such circumstances shall be made to the extent of  
11      the automobile insurance carrier's liability under the  
12      applicable contract, in accordance with fee schedules  
13      prescribed under section 10003(d), and such services  
14      shall be subject to all quality, cost containment, and  
15      anti-fraud and abuse provisions that apply generally  
16      to medical services provided by or through health  
17      plans.

18   **SEC. 10003. PAYMENT FOR AUTOMOBILE INSURANCE MEDI-**  
19                           **CAL SERVICES.**

20       (a) PAYMENT TO HEALTH PLANS.—Each automobile  
21      insurance carrier that is liable for payment for automobile  
22      insurance medical services provided to an injured individ-  
23      ual by a health plan shall make payment to the health  
24      plan for such services to the extent of its obligations under  
25      the applicable automobile insurance contract. Any feder-

1 ally funded health care plan shall have first priority, over  
2 the right of any other person, to receive payment pursuant  
3 to any obligation under an automobile insurance policy  
4 covering automobile insurance medical services.

5 (b) REIMBURSEMENT FOR COST SHARING.—Each  
6 automobile insurance carrier shall remain liable, to the ex-  
7 tent of its obligations under the applicable automobile in-  
8 surance contract, for reimbursement of any deductibles or  
9 coinsurance paid by an injured individual for automobile  
10 insurance medical services.

11 (c) LIMITATION OF LIABILITY.—Except with respect  
12 to payments to health plans as required by subsection (a)  
13 and to reimbursement of deductibles and coinsurance in  
14 accordance with subsection (b), nothing in this subtitle or  
15 any other provision of law shall require an automobile in-  
16 surance carrier or any person insured by such a carrier  
17 to make any payment to a health plan, health care pro-  
18 vider, or any other person for (1) automobile insurance  
19 medical services, or (2) other health care services or items  
20 used to treat an injury or illness sustained in an auto-  
21 mobile accident that are not medically necessary or appro-  
22 priate.

23 (d) USE OF FEE SCHEDULES.—

24 (1) IN GENERAL.—Irrespective of the type of  
25 health plan providing automobile insurance medical

1 services, payment by automobile insurance carriers  
2 for such services shall be made to the plan in ac-  
3 cordance with any fee schedule or schedules estab-  
4 lished for health care services generally. Each State  
5 shall develop or approve a fee schedule applicable to  
6 payment for any automobile insurance medical serv-  
7 ices that are not covered by a generally applicable  
8 fee schedule or schedules.

9 (2) ALTERNATIVE PAYMENT METHODOLO-  
10 GIES.—Fee schedules shall not be required in any  
11 case in which an automobile insurance carrier and a  
12 health plan have agreed on an alternative payment  
13 arrangement.

14 (e) REIMBURSEMENT FOR PAYMENTS MADE.—Noth-  
15 ing in this subtitle or any other provision of law shall im-  
16 pair the right of a health plan or automobile insurance  
17 carrier to seek reimbursement from any person liable for  
18 a bodily injury or illness sustained in an automobile acci-  
19 dent for payments made for automobile insurance medical  
20 services to treat such injury or illness.

21 (f) RIGHTS TO COVERAGE FOR ADDITIONAL TREAT-  
22 MENT.—Subject to the provisions of subsection (c), noth-  
23 ing in this subtitle shall impair any rights with respect  
24 to medically necessary or appropriate services and items  
25 to which an individual injured in an automobile accident



1 is entitled that are not automobile insurance medical serv-  
2 ices as defined in this subtitle.

3 **SEC. 10004. PAYMENT FACILITATION.**

4 (a) IN GENERAL.—In each State, an efficient and ef-  
5 fective system shall be established for prompt payment for  
6 automobile insurance medical services by automobile in-  
7 surance carriers to health plans. Such systems shall re-  
8 quire automobile insurance carriers and health plans to  
9 interface effectively, including through the use of cost-ef-  
10 fective computer data programs, in order to specify the  
11 automobile insurance carrier or carriers liable for payment  
12 for automobile insurance medical services. Such systems  
13 also shall include mechanisms for resolution, including ar-  
14 bitration, of any issues or disputes that may arise in con-  
15 nection with such payment. The results of the resolution  
16 of issues and disputes under the mechanisms prescribed  
17 pursuant to this subsection, including the use of any fee  
18 schedule under section 10003(d), shall be admissible in  
19 evidence only for purposes of recovery under section  
20 10003(e).

21 (b) SANCTIONS.—In each State, appropriate sanc-  
22 tions shall be prescribed for the failure of a health plan,  
23 an automobile insurance carrier, or any other person to  
24 comply with the requirements established pursuant to sub-  
25 section (a). Such sanctions shall include a penalty for late

1 payment, which shall be imposed on any automobile insur-  
2 ance carrier that delays payment to a health plan after  
3 the amount of reimbursement is established pursuant to  
4 the procedures prescribed under subsection (a).

5 **SEC. 10005. PAYMENT OF STATE ADMINISTRATIVE EX-**  
6 **PENSES.**

7 (a) IN GENERAL.—The Secretary of Health and  
8 Human Services shall provide for payment to each State,  
9 from the allotment to the State provided under subsection  
10 (b), of an amount equal to the amount expended by the  
11 State for administrative expenses in carrying out this sub-  
12 title in the State. Such payments shall be made at a time  
13 and manner specified by the Secretary and shall be condi-  
14 tioned upon the State providing the Secretary with such  
15 information as the Secretary may require in order to com-  
16 pute the appropriate amount of payments to be made.  
17 This subsection constitutes budget authority in advance  
18 of appropriations Acts, and represents the obligation of  
19 the Federal Government to provide payments to States in  
20 accordance with the applicable provisions of this section.

21 (b) STATE ALLOTMENT.—

22 (1) IN GENERAL.—The Secretary shall establish  
23 a formula for allotting among the States for each  
24 fiscal year the total amount of funds made available  
25 under paragraph (2) for the fiscal year.

1           (2) FUNDS AVAILABLE.—The total amount of  
2       funds available under this paragraph—

3                   (A) for fiscal year 1997 is \$300,000,000,  
4       and

5                   (B) for each succeeding fiscal year  
6       (through fiscal year 2004) is \$100,000,000.

7   **SEC. 10006. CONSTRUCTION.**

8       (a) COORDINATION WITH OTHER PROVISIONS OF  
9   THIS ACT.—The provisions of this subtitle shall be con-  
10   strued to be consistent with and shall be implemented in  
11   accordance with the other provisions of this Act.

12       (b) EFFECT ON WORKERS' COMPENSATION LAW.—  
13   Nothing in this subtitle shall affect rights or obligations  
14   under workers' compensation law.

15   **Subtitle B—Prefunding Govern-**  
16       **ment Health Benefits Contribu-**  
17       **tions**

18   **SEC. 10101. REQUIREMENT THAT CERTAIN AGENCIES**  
19               **PREFUND GOVERNMENT HEALTH BENEFITS**  
20               **CONTRIBUTIONS FOR THEIR ANNUITANTS.**

21       (a) DEFINITIONS.—For the purpose of this section—

22           (1) the term “agency” means any agency or  
23       other instrumentality within the executive branch of  
24       the Government, the receipts and disbursements of  
25       which are not generally included in the totals of the

1 budget of the United States Government submitted  
2 by the President;

3 (2) the term “health benefits plan” means, with  
4 respect to an agency, a health benefits plan, estab-  
5 lished by or under Federal law, in which employees  
6 or annuitants of such agency may participate;

7 (3) the term “health-benefits coverage” means  
8 coverage under a health benefits plan”;

9 (4) an individual shall be considered to be an  
10 “annuitant of an agency” if such individual is enti-  
11 tled to an annuity, under a retirement system estab-  
12 lished by or under Federal law, by virtue of—

13 (A) such individual’s service with, and sep-  
14 aration from, such agency; or

15 (B) being the survivor of an annuitant  
16 under subparagraph (A) or of an individual who  
17 died while employed by such agency; and

18 (5) the term “Office” means the Office of Per-  
19 sonnel Management.

20 (b) PREFUNDING REQUIREMENT.—

21 (1) IN GENERAL.—Effective as of October 1,  
22 1994, each agency (or February 1, 1995, in the case  
23 of the agency with the greatest number of employ-  
24 ees, as determined by the Office) shall be required  
25 to prepay the Government contributions which are

1 or will be required in connection with providing  
2 health-benefits coverage for annuitants of such agen-  
3 cy.

4 (2) REGULATIONS.—The Office shall prescribe  
5 such regulations as may be necessary to carry out  
6 this section. The regulations shall be designed to en-  
7 sure at least the following:

8 (A) Amounts paid by each agency shall be  
9 sufficient to cover the amounts which would  
10 otherwise be payable by such agency (on a  
11 “pay-as-you-go” basis), on or after the applica-  
12 ble effective date under paragraph (1), on be-  
13 half of—

14 (i) individuals who are annuitants of  
15 the agency as of such effective date; and

16 (ii) individuals who are employed by  
17 the agency as of such effective date, or  
18 who become employed by the agency after  
19 such effective date, after such individuals  
20 have become annuitants of the agency (in-  
21 cluding their survivors).

22 (B)(i) For purposes of determining any  
23 amounts payable by an agency—

24 (I) this section shall be treated as if  
25 it had taken effect at the beginning of the

1           20-year period which ends on the effective  
2           date applicable under paragraph (1) with  
3           respect to such agency; and

4                   (II) in addition to any amounts pay-  
5           able under subparagraph (A), each agency  
6           shall also be responsible for paying any  
7           amounts for which it would have been re-  
8           sponsible, with respect to the 20-year pe-  
9           riod described in subclause (I), in connec-  
10          tion with any individuals who are annu-  
11          itants or employees of the agency as of the  
12          applicable effective date under paragraph  
13          (1).

14                   (ii) Any amounts payable under this sub-  
15          paragraph for periods preceding the applicable  
16          effective date under paragraph (1) shall be pay-  
17          able in equal installments over the 20-year pe-  
18          riod beginning on such effective date.

19          (c) FASB STANDARDS.—Regulations under sub-  
20          section (b) shall be in conformance with the provisions of  
21          standard 106 of the Financial Accounting Standards  
22          Board, issued in December 1990.

23          (d) CLARIFICATION.—Nothing in this section shall be  
24          considered to permit or require duplicative payments on  
25          behalf of any individuals.

1       (e) DRAFT LEGISLATION.—The Office shall prepare  
2 and submit to Congress any draft legislation which may  
3 be necessary in order to carry out this section.

